

# THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services*

Vol. XIX

November 1922

No. 5

## AN ECONOMICALLY BUILT SMALL HOSPITAL

BY G. R. EGELAND, M.D., STURGEON BAY, WIS.

THE Egeland Hospital was built to serve a community of 5,000 people. It draws, however, from a radius of some forty miles from a county of over 20,000, with an additional summer population of some 5,000. With the exception of a small frame hospital of fifteen beds and very limited equipment, it offers the only hospital facilities for this large population.

Small communities, up to seven and eight thousand inhabitants, at a distance from large cities are very often handicapped by lack of hospital facilities and the result is that many emergency cases are lost for lack of proper care. Medical men in such communities are likely to get into

The writer practiced ten years in the country, thirty miles from a hospital which was one simply in name and which lacked equipment. Many hardships had to be endured to get the sufferers to a place of help and lives were lost for lack of proper facilities.

Seven years ago I bought a large frame building and converted it into a hospital. I equipped it as well as it could be equipped and then dreamed and studied the problem of building a hospital of twenty-five bed capacity.

On February 12, 1920, the old building was destroyed and the building of a hospital became a real question. The first plan was a community



The Egeland Hospital in its winter setting. How summer enhances its attractiveness may be seen by the view on the cover page.

a line of contentment with themselves and make no effort toward advancement, and thereby the trusting public suffers.

In every locality there should be a hospital for the care of suffering humanity, and every man or woman graduate in medicine should have access to a hospital properly equipped and should use it. Where that is done the highest possible service is rendered to the sick, because each one will try to excel, and the human family is the gainer.

hospital of seventy-five beds, but in a city of 5,000, factions and cliques are bound to exist and after six or seven months of wrangling and work, the hospital committee had only \$7,500 in pledges on a \$100,000 proposition. It was obvious that if I wanted a hospital I had to build one myself; which I did.

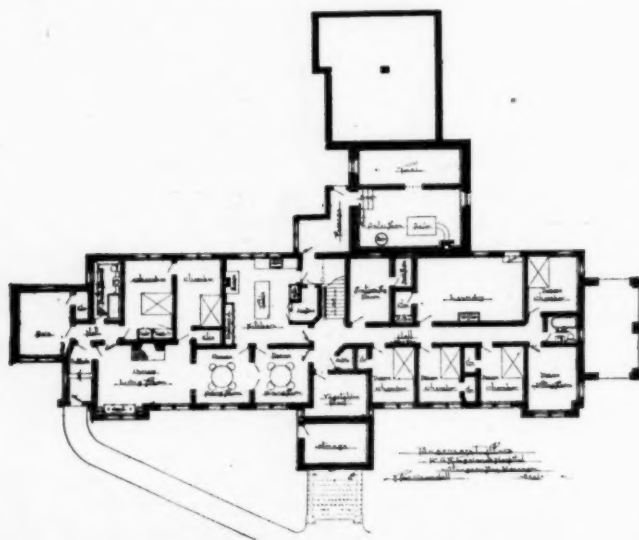
Everybody knows that as an investment hospitals are the least likely to pay; the fact is that no hospital should be a commercial enterprise.

When the great brotherhood of man becomes a real fact, hospitals will be maintained by the state for the care of suffering humanity and the dollars and cents will be stricken from the records, but until that day the money for maintenance must come from some source and as a result the sick and needy pay the upkeep.

The man who has fire loss does not maintain the fire department, nor does the man who is robbed pay for the police and detective force, but those who are sick and in need must maintain the hospitals. Let us hope that at some future time the well folks will maintain our institutions and the sick get just the best the land affords at the least cost to them when in need.

The Egeland Hospital is located on a commanding site, away from the noise of business and traffic, with sunny exposure. The style of architecture is shown in one of the accompanying half tone photographs which was taken at the time of the completion of the building and before the grounds had been finished. The main building is 106 feet long, 18 feet on the east end for the operating room and with a 16 foot sun porch on the west end. It is a frame construction, the exterior of rough cast white medusa cement, the cornice, columns and rail of portico are of wood, painted white. The basement contains the living quarters of the owner, with private entrance, nurses' living quarters with bath, laundry, roentgen ray dark room and vegetable cellar. The kitchen on this floor has a dumb waiter leading to the floor above and a large ice box, as shown on the plan. The first floor has rooms for patients, serving kitchen, sink, toilets, bath, linen room and office.

All stairways are broad and are easily ascended. The interior finish is simple in char-



Basement plan of Egeland Hospital



First floor plan of Egeland Hospital

acter, with due regard to hygienic construction and ease of maintenance.

### Flooring Materials in Use

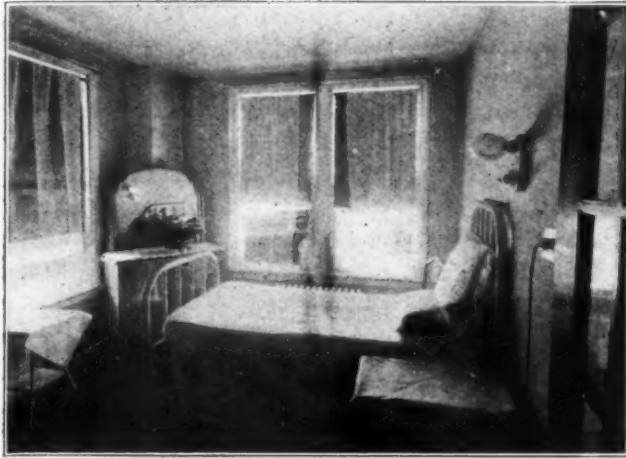
The floors in operating room, sterilizing room, utility room, waiting room, office, baths and toilets are of tile as indicated on the plans. The operating room, sterilizing room and bath rooms have a five foot wainscoting of white glazed tile.

The other floors in this story, not mentioned above, are covered with battleship linoleum. All the doors are inlaid birch no-panel hospital type, three feet four inches wide for patients' rooms, to permit beds occupied by patients to be taken out. The entire woodwork on this floor is finished in white enamel, except doors which are stained mahogany, wax finish. The casings are three inches in width and  $\frac{3}{4}$ -inch thick; round edges reduce dust collection, and being so narrow the casings can be cleaned with one movement of the arm. The corridor on this floor is seven feet four inches wide and is well lighted by two large skylights, as indicated. The width of corridor permits the easy turning of beds with patients when necessary.

The heating plant for this building is placed in a fireproof enclosure entirely shut off from the hospital proper; the roof is of reinforced concrete six inches thick.

The hospital is heated by an accelerated hot water heating system. The high pressure steam sterilizing equipment is supplied by a small high pressure steam boiler located in the room occupied by the heating plant. The entire building is completely equipped with modern plumbing fixtures, including fire hydrants as shown on the plans. The hospital has city sewer and water con-





A private room at Egeland Hospital.

nections and its private water system for use of hospital is absolutely pure by test.

The operating room is placed out from the building, thereby getting the north, east and south light without skylights, which at their best are troublesome, because of leakage. The sterilizing room and wash room, laboratory and surgeon's rooms are together at the east end of the building and protected from the main hall by a double set of doors, which keep out noise and odors from the balance of the building. The laboratory, drug room, and surgeon's dressing room combine very well and take but small space. If separated they require a great deal of space, which is a loss.

The utility room, linen room and serving kitchen were centralized to reduce labor for the nurses. The front and rear entrances are centralized and are opposite each other giving good air drainage, and the halls are wide making it easy to get patients both in and out. The rear entrance is also an ambulance entrance.

Experience has taught me that large wards in small hospitals are not popular. Anything above two beds is very likely to bring trouble. The element of jealousy easily enters the minds of the sick; they can very quickly find that one patient receives more care and service than another and difficulty results. Two people can very easily be congenial but not six, therefore, I had five two-bed wards, which in an emergency can be made to hold three and still have the cubic feet of air necessary, and nine single rooms, which in emergency can hold two, and after a year's run I find

that arrangement to be highly satisfactory.

The sun porch at the west end of the building was to balance, from an architectural standpoint, the operating room on the east end, but it is much more than a balance. During the warm weather it is used as a recovery room from anesthetics, convalescing patients are wheeled out there daily for air, either in wheel chairs or in their own beds, and during congested times it can be closed up and used as a large ward.

The isolation ward was a part of the old building, which remained after the fire. It is a great convenience, being away from the hospital proper, but close enough to be operated in all ways from the main building. Such a ward should be built near all hospitals for use in emergencies which are bound to arise in hospital work.

From my past experience I find maintenance means much and the more hospital you can get on one floor, the less is the cost per head of upkeep. Housing your help in the same building means that you always have them with you and they become more like a large family engaged with you in the care of the sick.

Living in the hospital yourself reduces your personal expenses and has the advantage of keeping you always with your patients. It has had sides, such as never getting you away from work, but taking everything together the man who goes in for a privately owned hospital had better live with his work than away from it. Patients are a law unto themselves and have to be known. Being with them all the time a man learns and knows every detail and

can give the patients much real comfort by relieving pain, for no order left on a history sheet, to be carried out by a nurse, can be entirely adequate and this personal care may be very important to the sufferer.



The main hall looking east into the operating room.



A contented little patient

Keeping down the cost of the building has made it possible for us to have thoroughly first rate equipment. We have a first-class operating table, a battery of four high pressure steam sterilizers, plus electric sterilizers for instruments, and water which is used when the high pressure one for any reason is not in use. This obviates the necessity of continually keeping a great head of steam.

Protecting the patients from external sources of danger, such as fire, is of primary importance and while fireproof construction is ideal the cost is such that it is prohibitive for private enterprise or a small community. By attention to details an institution such as I am now presenting can be built in which danger from fire is minimized and where I believe the patients are perfectly safe. The construction throughout might be called semi-fireproof. The outside of the building being rough coated with stucco, with a fireproof roof, has very little exposed wood. The heating plant, high pressure boiler for sterilizer and coal supply are placed in the basement, which is absolutely fireproof, and the only fire within is the cooking stove, which is protected in every possible way. All electric wires are laid in steel conduits. There is not an exposed wire within the building. The partitions and the lower floors are concrete filled, making for strength and stopping fire. A plaster board is used throughout, which is fireproof. The lower floors are laid upon sleepers laid in concrete which have an inch and one-half of air space. There is, therefore, no possibility of rats or mice getting into the building and beneath the floors.

Each door will allow the passage of the bed, with the patient upon it, into the hall and out of the building, and all beds are mounted on six inch casters so that they can be rolled anywhere with ease by one nurse. I estimate that without extra help the building could be emptied without discomfort to the patients in less than one-half hour.

The roentgen ray room was placed in the living quarters, because there was space there for such a room (in which no light could be brought) owing to the position of the boiler room, and also

to give more real hospital space on the upper floor; the arrangement, however, is not satisfactory. This room should be next to the operating department, particularly for fracture work. The lack of an elevator in this building makes the position of this room very inconvenient in fracture work, patients having to be carried to and from up a flight of stairs.

The laundry room was converted into a drying room and the laundry placed away from the building. The odor and steam from a laundry in the building make it objectionable, but a drying room is not offensive.

The hospital, while strictly privately owned, is run for the general public and any man can operate his cases here if he is capable and so chooses.

The upkeep and expense of maintenance must come from receipts from patients or the owner must make good any deficit; there are no contributions or endowments. So far the hospital has been self-supporting, but should it not pay, the increased ability to do work, the better class of work that can be done, and the general satisfaction of being better able to help suffering humanity would compensate for any cost it may be to the owner.

The fireproof roof, enclosed wiring, separate heating plant, and other items I have mentioned would make the building a slow burning



The operating room through the windows of which may be seen a lovely garden of flowers and shrubbery.

one. With the consideration which I have given to these details and to the problem of getting patients out in times of emergency without extra help, I feel that while we are not strictly fireproof we are very safe from fire for the patients, and the cost of construction has been held down to a point where any community can have an adequately equipped hospital.

The plea I want to make in presenting the account of this hospital is first: Keep the building code of the various states so that hospitals can be built safe for the patients, but not at a prohibitive cost, and second, build small hospitals in all communities thereby saving human life and making doctors more efficient and better men.

The greatest truths are the simplest; and so are the greatest men.—Hare.



## SOME FACTS ABOUT FIRE INSURANCE AND LOSS ADJUSTMENTS

By PHILIP G. CLIFTON, CHICAGO.

LET it be understood at the start that there is no deep mystery about fire insurance. Neither is the insurance policy contract a document bristling with provisos, prohibitions and stipulations to trap the unwary business man. And strange as it may seem, adjustments are not made on the principle of paying as little as possibly can be paid.

It is true that fire insurance as it stands today is the result of development. And like all businesses there has undoubtedly been in this certain mistakes and abuses. These past mistakes have been magnified and their history has been so frequently reiterated that many believe there is a question as to the validity of any insurance policy.

Big men at the head of large concerns seriously believe that insurance companies can easily find loopholes so that they need not adhere to the contract in settling losses. But this opinion is the result of not knowing the requirements of the contract.

Ignorance of any proposition breeds suspicion or carelessness. Policies are rarely read and imperfectly understood when read. Any general contract offered to the public at large must have certain restrictions and must contain requirements on the part of the insurer and the insured in order mutually to protect both their interests. It is a fallacy that their interests are different—they are identical.

With but few exceptions fire insurance companies use a state standard form policy made mandatory by the state in which they operate. The New York standard form of policy is the one that is generally used as it embraces nearly all that is contained in other forms. One familiar with its requirements can readily understand the amendments that any state makes.

Earlier insurance contracts had their faults. Each company endeavored to make its contract as attractive as possible. Rates were not uniform.

### NO MYSTERY ABOUT INSURANCE

*"An insurance policy contract is not a document bristling with provisos, prohibitions and stipulations to trap the unwary business man," says the author of the accompanying article who is connected with an appraisal company of high standing. "Ignorance of any proposition breeds suspicion or carelessness. Policies are rarely read and imperfectly understood when read. Any general contract offered to the public at large must have certain restrictions and certain requirements on the part of the insurer and the insured in order mutually to protect both their interests. It is a fallacy that their interests are different—they are identical."*

The operation of swindlers, together with the confusion in adjustments caused by different contracts on the same loss, created an intolerable condition. This was remedied by state supervision and a standard form of contract.

The New York standard form is the best example. The fact that it has stood the test for years is evidence that it is equitable to the policy holder and to the insurance company.

The rider form directly applies the insurance to fit the facts and conditions of the particular risk. It also amends the standard form, which is not a contract until completed by descriptions and amendments. The rider form should give the correct name of the assured and should correctly describe the property insured.

The drafting of rider forms is standardized to a large extent. Concerns in some lines of industry require broader permits than others. It is no advantage to have any broader permits than the business requires.

No one is better qualified than the informed agent or broker to draft a form that fully protects the owner against loss. The agent is thoroughly familiar with the risk offered and he is in position to know what permits fit the condition. While he is the "agent for the company" his business success depends upon how well he serves the owner. Many agents and brokers have their own inspectors, who give the owner much service in addition to that of inspection bureaus.

The agent knows that to secure a permanent client he must suggest changes to lower the rates. The best and largest agencies have been built up on that kind of service, the popular belief to the contrary notwithstanding.

### Coinurance

Probably the greatest factor in the reduction of fire insurance rates has been the use of the co-insurance clause. Instead of being a hardship on the owner, it has been a blessing. Were not co-



insurance in force on the major portions of sizable risks in the country the rates would be much more. There has been mistaken legislation in some states prohibiting its use. Were it not for coinsurance the blanket form of insurance could not be used.

Coinurance is a form of insurance in which the person who insures his property for less than its entire value is understood to be his own insurer for the difference which exists between the actual cash value of the property and the amount of the insurance. When the loss is not greater than the insurance the amount paid is in the ratio of the total amount of insurance to the full value of the property.

A great many business men object to the coinsurance clause because they think that it means that the insurance company will pay only a certain proportion of any given loss. This is, of course, a mistaken idea. The clause has no effect whatever on the adjustment of losses, *if the clause is lived up to by the assured*. It is only when the assured does not maintain the agreed amount of insurance in proportion to value that the clause is operative.

All business men should, if they have not already done so, ascertain accurately the present value of the property they wish to have insured, and then take steps to have their insurance amount to the agreed percentage (usually 80 per cent) of such value. If this is done, the insured will be entitled to collect any losses he may have, just as if the clause were not attached to the policy.

The most usual coinsurance clause is based on the assured agreeing to carry 80 per cent of the value of his property, and the following example, worked out on the basis of varying increases in value, will, I think, illustrate clearly the operation of the clause:

EXAMPLE OF 80 PER CENT COINSURANCE CLAUSE			
Three years ago:			
Value of building and contents.....	\$50,000		
Insurance carried .....	40,000		
Loss by fire.....	10,000		
Paid by insurance company.....		\$10,000	
Now:			
Value of building and contents.....	\$75,000		
Assured should carry 80 per cent of value or.....	60,000		
*Insurance carried .....	45,000		
Loss by fire .....	10,000		
Paid by insurance company—75 per cent of loss, or		\$7,500	
Assured must bear 25 per cent of the loss, or.....		2,500	

\*Insurance carried is only 75 per cent of what assured should carry to comply with the requirements of the 80 per cent clause.

### Adjusting the Fire Loss

The humorist Bill Nye once defined an insurance adjuster as "one who stands between the insured and immediate wealth." In the next sentence he states "if it were not for the adjuster the insurance company would soon give away all its wealth and fetch up in the poorhouse."

In the entire ramification of insurance no phase

of the business is more difficult or more important than that of adjustment of losses. The business man judges the entire system of insurance by the manner in which his loss is settled.

The insurance companies employ the best talent obtainable to handle their adjustments. These adjusters are skilled in gaining the claimant's confidence and their endeavor is to make a settlement that is fair to the owner and to the companies they represent.

The adjuster for the insurance companies has the advantage to the extent that loss adjustments are his every day business. He has a complete understanding of the contract conditions and knows every procedure in making the settlement.

However, the adjuster frequently believes that the owner has the advantage because the adjustment depends to a large extent upon the integrity of the loss claimant and the records that he produces.

Adjusters view a loss from an impersonal, professional standpoint with full realization that their own money is not involved and their own business is not in jeopardy. On the contrary the loss claimant cannot view the matter impersonally because his money and business are involved. Added to this disadvantage to the owner is the fact that he rarely knows what is expected of him and the principles underlying adjustments.

The situation calls for cool-headed consideration by both the claimant and the adjuster. Patient analysis will disclose that differences are largely imaginary and that cooperation will be beneficial to both.

The business man who waits until a loss occurs to find out what he should have done, may find himself in the position of one who "locks the stable door after the horse has been stolen."

There are two points relating to values that many business men do not realize until they have actually gone through an adjustment: first, that *the adjustment is made on the basis of the cash value at the time of fire* not the value at the time the insurance was taken out; second, that the adjustment is made on the sound or depreciated value, not the value to replace new.

Upon reflection it will be seen that both these points are proper and just.

The insurance policy is a personal contract. Strictly speaking, it does not insure the property; it indemnifies the policyholder for loss accruing to him personally by reason of the damage or destruction of certain property at the time of the fire. At the time the insurance was placed on a stock of flour its actual value, we will assume, was \$1,000. Later at the time of the fire, its actual value was \$1,200. Were the loss settled on

the basis of the \$1,000 valuation the owner would lose \$200. On the other hand, were its value \$800 when the fire occurred the insurance company would lose \$200 if the company settles for \$1,000. Settling the loss on the basis of the actual value at the time of the fire prevents loss to either the owner or the company. This is equitable and just.

Were losses settled on the basis of the value to replace new, the property a moral hazard would be created which would put a premium upon dishonesty and carelessness. Insurance companies must provide surpluses through the medium of premiums to meet the losses; therefore, the more losses, the larger premiums.

Line 2 of the New York standard policy reads: "This company shall not be liable beyond the cash value of the property at the time any loss or damage occurs."

The legal definition of actual cash value is "that resultant value obtained by deducting from the replacement value new, the actual depreciation." Any system of valuation that accurately determines the value to replace the property new, the amount of actual accrued depreciation and the resultant sound value, will be accepted by adjusters. Systems have been devised which bring accurate results.

To assist the adjuster in obtaining the essential facts, the policy makes it obligatory for the owner to make, in case of personal property, a complete inventory of the same, stating quantity and cost of each article and the amount of loss claimed thereon. This provision has led many to believe erroneously that the loss was settled on the past cost. The owner has sixty days in which to make this schedule. The company grants more time if necessary.

### Valuation and Depreciation

Insurance is paid upon the basis of the cash value of the property at the time and the place the loss occurs.

Book records of past costs of property do not show the cost to replace the property new at the time of the fire, neither do they show the actual depreciation. Since the cost to replace property items are constantly fluctuating and depreciation is not occurring at a uniform rate, the book records no matter how accurately kept, cannot be used for adjustment purposes.

Many old properties have been "charged off" upon the books of account and consequently represent no value. This does not in any way change their actual intrinsic value and, if loss occurs, the owners of these plants are entitled to present claim for cost of replacement less accrued depreciation.

Original cost is seldom the same as today's real value; property value is rarely the same thing as the total of plant investment; and neither the original cost nor the investment is the same thing as today's cost of reproduction less the depreciation.

Books of account, if properly kept, show investment of original cost. Appraisals, if properly made, show the present cost to duplicate the property, the actual accrued depreciation and the resultant sound value.

How the values on the books of account would differ because of a difference in the policy of two managements is shown by the following illustrations:

Ten years ago Management "A" takes a new property whose asset value is \$100,000. It decides to "write off" 10 per cent annually for depreciation. The books of account would show the plant account of the original property to be at this time about \$39,000. If Management "B" had taken charge of the property and had decided to "write off" 5 per cent annually its plant account would be approximately \$63,000.

A correct appraisal would show that the actual value of the property was the same for Management "A" as for Management "B." The books of account show simply as an account procedure, a depreciation which is an arbitrary percentage determined usually by custom or circumstances related more to "balance sheets" than to actual wear and tear.

One must not conclude that the custom of "writing off" an annual, uniform depreciation is wrong as a business policy. It is, however, wrong to consider such depreciations as the "actual depreciation." Actual depreciation must not be confused with theoretical depreciation. The two are different and should be used each for its particular purposes.

Because of the theoretical system of accounting, book depreciations are not actual depreciations, and because the insurance contract pays on the basis of actual depreciation, the service of making appraisals has come into existence. Many business men consider it rather a delicate situation to be the source of two different bases of value. For this reason and for reasons of economy and efficiency, many concerns employ the services of professional appraisers. They realize that with a correct disinterested, authoritative appraisal report all interests depending upon actual values are amply protected.

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Gentleness and cheerfulness, these come before all morality; they are the perfect duties. \* \* \* If your morals make you dreary, depend upon it they are wrong.  
—R. L. Stevenson.



## IOWA COLLEGE TOWN HAS ACTIVE COMMUNITY HOSPITAL

By LUTIE B. LARSEN, SUPERINTENDENT, GRINNELL COMMUNITY HOSPITAL, GRINNELL, IOWA.

**T**HE Grinnell Community Hospital is the outgrowth of several factors; chief among these was the need for better care for the sick in the community.

In 1907 several public-spirited citizens bought and equipped an old residence to be used as a hospital, the city voting a tax to pay the deficit in operating expenses. This hospital was soon outgrown and in 1918 an active movement was begun to raise funds for a real community hospital. A site and \$75,000 were given by popular stock subscription. Later, by reason of further gifts, the site was changed and a full city block purchased for about \$10,000, leaving \$90,000 for building and equipment.

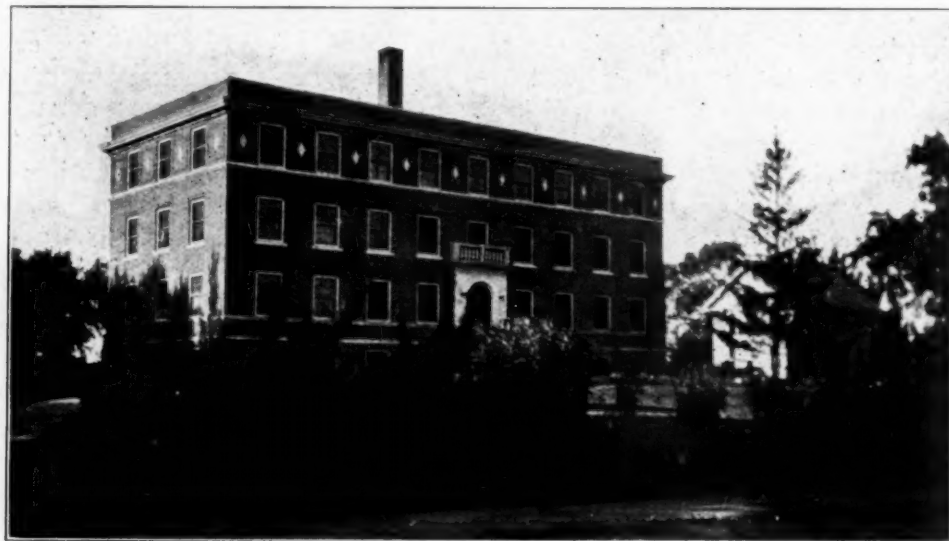
A modern fireproof building with accommodations for forty-five patients was constructed and was ready for service August 1, 1919. The main building, of brick, is 38x88 feet, three stories and basement with terrazzo floors throughout. In the basement are the kitchen, dining rooms, store

The location and surroundings of the hospital are especially attractive. The hospital stands in the middle of a full city block and everything in the way of landscape gardening has been done to make the place attractive. It is hoped that in the near future it may be possible to build a modern nurses' home on the grounds in the rear.

The ambulance entrance is at the rear. Just inside the rear entrance there is an electric elevator which makes for easy transportation to any floor, of any kind of case, whether wheel chair or stretcher.

### Yearly Tickets Entitle Students to Care

In planning this hospital, the necessity for an isolation hospital was not lost sight of. Grinnell, being a college town and having from 900 to 1,000 students, probably needs a contagious department more than most towns of its size. This, a small building of stucco entirely separated from the main one, accommodates twelve patients and has



The Grinnell Community Hospital houses 45 patients.

rooms, laundry, classroom, boiler room, rooms for help, and the laboratory. The first floor is partly for administration and partly for patients. The second floor is devoted entirely to the care of patients. One half of the third floor is occupied by the operating and x-ray rooms, the other half by the obstetrical department. On the first floor, in the rear, is a large porch; on the second and third floors are large solariums. A signal system is installed throughout the building.

been very useful since its opening. Many students from the college have been cared for and many citizens of the town have found it much more convenient to go to the hospital than to have the home quarantined. The usefulness of the place is more apparent every year and the patronage has shown a steady increase since its opening. The expense and care of contagious disease in the home is so much greater than in an institution that more and more those who are afflicted with



contagious diseases are seeking the care offered by this department.

"Student insurance" was issued in the fall of 1921 by the hospital management. This provides for care in the hospital in case of illness. At the



The grounds are ample and pleasingly landscaped.

beginning of the school year the student may purchase a "hospital ticket" which costs \$5 for the year or \$3 for a semester. This entitles the student to hospital care for a period not to exceed three weeks. This includes board, room, laundry, medical dressings and nursing care. It does not include special nursing care, x-ray, operating room or laboratory fees. This fee is payable with the tuition at the college office.

This insurance is, I believe, an original idea as I cannot learn of any other hospital giving such insurance. It has proved very satisfactory to both the student and to the hospital, and has found such favor with the faculty of the college that the members have asked to have some kind of insurance arranged for them. This will probably be done.

The laboratory is well equipped for all the routine hospital work, including the various bacteriological procedures and blood chemistry. It has almost since the beginning been an authorized branch of the state board of health laboratory, and in the year 1921, 475 examinations were made for diphtheria. The average total number of examinations per month was 104. Every issue removed at operation was examined grossly and microscopically and recorded. It has been a house rule to do a routine urinalysis and leucocyte count on all operative cases, and the coagulation time taken on all patients entered for tonsillectomy.

During the past year and a half the laboratory has been in charge of a graduate physician who devotes her entire time to pathology, doing work for local physicians when not busy in the hospital.

The x-ray department consists of one large main room and a smaller dark room. It is in

charge of a physician-roentgenologist who is also the pediatrician.

A child welfare clinic was established through the generosity of one of Grinnell's leading citizens. Clinics are held twice a month and excellent work is being done. Scores of unnoticed defects have been pointed out, and children from nearby towns and many who are merely visitors have availed themselves of the opportunity for a thorough examination. It is free to anyone who desires to bring children to the clinic.

In cooperation with the Social Service League a free dispensary has been opened. The secretary of the Social Service League after making sure the applicant is really unable to pay for medical



A rear view of the hospital building. The ambulance entrance is here.

aid, issues a ticket which entitles the holder to free examination and treatment. Though the demand in this kind of a community is not large, we have during the past winter given aid to many, for here as elsewhere there has been unemployment.

### Prenatal Clinic Gives Needed Help

A prenatal clinic was opened the first part of 1922 but so far has not been well patronized. It is a new idea in this locality and its benefits are as yet not understood by the public, but we are undismayed and feel it can be developed. The department is in charge of the superintendent. It does not include medical or obstetrical care, for this the patient is referred back to the family physician. It is simply a round table with the expectant mother to advise her about small things with which she would not think of troubling her physician, to advise in regard to the baby's layette, to emphasize the necessity of personal hygiene, etc.

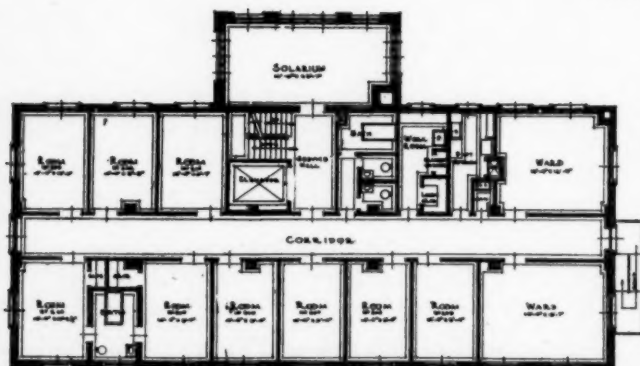
We have our share of charity cases, some of which are paid for by the county; a few are cared for by a generous citizen who has provided \$500 per year for this purpose, and this amount is always overdrawn. Some time this year we hope



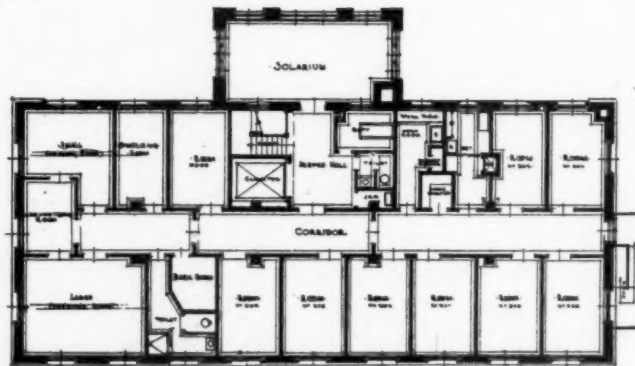
Basement plan of the Grinnell Community Hospital.



First floor plan.



Second floor plan.



Third floor plan.



The laboratory is equipped with some completeness and is an authorized branch of the state board of health laboratory.

to have a financial campaign to help make up our deficit. We recently received a legacy of \$25,000 and when that is available it will be made the nucleus for an endowment fund.

In the early part of the first year a training school was established. It is accredited and has affiliation with the State University Hospital at Iowa City. Each nurse during her senior year has six months' service in that hospital. We have just graduated our first class, a class of only two.

The staff of the hospital is composed of most of the regular reputable physicians of the town and one or two from each of the neighboring towns in a twenty mile radius. The staff has a general direction over the professional conduct of the institution, but only licensed practitioners are allowed to practice in the hospital at present. The effort to meet the requirements of standardization has not been a complete success, owing partly to the conflict of the personal equation among the members of the staff. Pressure along this line is continually exerted, however, and it is expected



Another actively functioning corner of the laboratory.

that opposition will eventually be overcome and the requirements established to the satisfaction of all concerned.

Once in two months we issue a hospital bulletin. In this way we try to convey to the public our needs and what is being done in the hospital. We publish the names of those who have contributed since the last issue, items of interest in the training school and similar notes. Now we are urging the necessity for a nurses' home.

Looking back upon the last three years we feel that much has been accomplished and this gives us reason to hope that the next few years will find us steadily increasing our usefulness in the community. \*

#### AIDS CHINESE HOSPITALS BY MEANS OF MEDICAL SCHOOLS

The experience of the China Medical Board of the Rockefeller Foundation seems to indicate that the most effective way to aid the hospitals in China is to improve and extend the facilities for training of doctors, nurses, and technical workers of various kinds who cannot now be found in adequate numbers in China or abroad, even when funds for their support are available, says the recent annual report of the board.

"In practically all countries it is recognized that even those hospitals which are not connected with medical schools have important educational functions to perform. This is particularly true of the hospitals in China. Besides training interns and nurses they provide opportunities for the continued employment of young doctors who need the facilities of the hospital and the friendly guidance of more experienced men if they are to continue their professional growth. Local medical associations in China have been little developed; there are no medical libraries except in the schools; and outside of a few large cities there is no systematic provision for stimulating professional intercourse between practicing physicians. Association with a good hospital can do much to compensate for these disadvantages, and thus conserve for future usefulness the men turned out by the schools.

"The hospital has also a useful part to play in the education of the public. In many cases the mission hospital is the only place where modern medicine is practiced, and the only center for popular health education."

Since the China Medical Board began its work in 1915, grants have been made to mission hospitals to enable them to improve their work, through additions to plant and equipment or through increases of staff and maintenance appropriations. In 1921 payments were made to sixteen such institutions, amounting to \$123,986.

#### DR. RAPPEYE TO NEW HAVEN HOSPITAL

Dr. Willard C. Rappleye, secretary of the Committee on the Training of Hospital Executives which recently submitted its outstanding report, has been named head of the New Haven Hospital, the teaching institution of Yale University and professor of hospital administration at Yale medical school. Dr. Rappleye succeeds Dr. Harold W. Hersey, now connected with the Joint Administrative Board of Columbia University and Presbyterian Hospital, New York. Dr. Rappleye was formerly director of hospitals for the University of California.



## A PROPER LOCATION FOR THE HOSPITAL PHARMACY

BY RICHARD RESLER, RESLER & HESSELBACH, ARCHITECTURAL AND CONSULTING ENGINEERS, NEW YORK.

THE preparation of this paper has been prompted by the writer's investigations and observations of certain existing hospitals and others in course of construction wherein a lack of sound study of the necessary requirements for the proper and efficient location of the pharmacy and drug storage room has manifested itself.

The size of the pharmacy is dependent to a great extent on the character of the institution, and its class of work. Obviously the drug requirements of an orthopedic hospital differ from those of a general hospital. Then the question of drug preparation was of more importance twenty years ago than now, for there are a number of physicians and surgeons at the present time who are depending to a certain extent for the cure of their patients upon dietotherapy.

Whether the pharmacy should be included in the plans for the first or ground floor must be governed by local conditions, such as the topography of the property, approach to the hospital, orientation, location of the hospital entrance and out-patient department. These are positive contributing factors in arriving at a proper and efficient location.

### Central Location is Essential

In view of the fact that all medicines, both special prescriptions and proprietary, radiate from the hospital pharmacy it is manifest that this important department should by all means be centrally located to reduce to a minimum the many services therefrom.

In a typical general hospital *without* an out-patient department the pharmacy should be located as nearly equi-distant to the extreme ends of the hospital patient service as is possible and at the same time it should be convenient to the elevator and stairs. In an institution *with* an out-patient department it is important to locate the pharmacy convenient to this department with one window serving it and another the hospital proper.

In a hospital group it is highly desirable to locate the pharmacy in so far as is practicable equi-distant to the ward buildings. In case provision is made for the out-patient department in the administration building it is preferable for the pharmacy to be located in this building.

In planning for pharmacies it must be borne in mind that the pharmacy itself is a room wherein drug preparations are made and dispensed with

an amount of drug storage sufficient for current needs only, therefore the drug storage room, which in reality is an integral part of the pharmacy, should be located convenient thereto. If it is not possible to locate the drug storage room adjacent, it should be located directly under the pharmacy with a connecting stairs.

The subject of drug storage is an important one and should be seriously studied with a view to providing adequate facilities for the storage of and access to the various cases and barrels. It frequently happens that opportunity is presented the institution to purchase drugs from the wholesale drug house in bulk at a considerable saving in cost, and in order to permit the hospital to avail itself of such an economical procedure it is necessary to provide storage for this purpose.

Open shelving should be provided in the drug storage room for bottled and cased medicines, with racks properly tilted to draw off the supply from kegs and barrels. In a small institution storage for barreled supplies is not nearly so necessary, as the purchase is usually made in smaller quantities. Space must be allowed for special manufactured supplies made up in large quantities by the wholesaler on prescription and a storage vault for combustibles opening directly off the dry storage room is desirable.

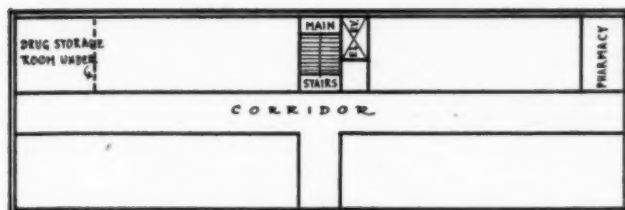
Since the life of certain drugs is seriously impaired by dampness the drug storage room and pharmacy should be perfectly dry and well ventilated.

Frequently the pharmacy is located in what originally was vacant space with the result that the room is not only poorly ventilated but is deficient in natural daylight. The pharmacy should receive as careful consideration from the standpoint of daylight as an operating room. Large windows which extend up to the ceiling with a north light are preferable.

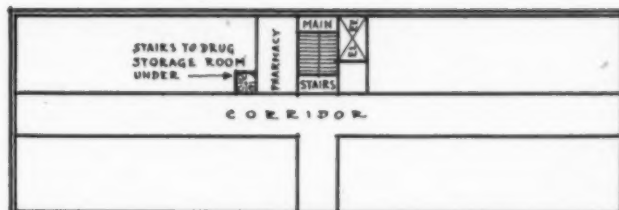
### Wood Floors and Tables Preferable

The pharmacy proper whether in a general hospital or one with an out-patient department should be planned carefully to minimize the steps of the druggist or his assistants. From the writers' investigations and inquiries among hospital pharmacists, it is found that a wood finished floor is preferable not only from the standpoint of resiliency but as a saving in glass breakage.

Breakage of glassware, such as bottles, stoppers, graduates, funnels, mixers, etc., amounts to



(A) A layout to be avoided.



(B) A conveniently located pharmacy.

a great sum by the end of the year. It seems desirable to construct all counters and work tables of wood in order to minimize this breakage.

The pharmacy should be provided with cabinets along the wall to a height of approximately 37 inches from the floor for the storage of small cases and canned drugs. They can be finished with counters at the top.

A number of small drawers should be provided for proprietary medicines made up in the shape of pills and capsules. The upper part of the cabinet should have open shelving approximately 10 inches on center with the shelves about 6 inches wide, adjustable but firmly fastened, to obviate the danger of upsetting the entire shelf in case one of the bottles sticks, a situation which frequently results in considerable damage.

A section of the shelving should be enclosed with glazed doors equipped with a separate locking device so that poisons and narcotics can be stored.

It is desirable to provide space for a pharmacist's desk, filing cabinet and storage of stationery, such as prescription pads and labels. Racks with notches in them are convenient for hanging glass funnels and graduates. Storage for empty glass bottles should be provided.

#### Some Necessary Equipment

Alberene stone appears the most desirable material for drug sink and drain boards. Hot and cold water should be provided with gooseneck faucets set a height above the sink sufficient to permit the filling of bottles at least of five gallon capacity. Should the hospital not be equipped with a central water still, a small one should be installed in the pharmacy in a convenient location on the wall.

Electric and gas outlets should be furnished and a small refrigerator for the storage of serums and vaccines should be provided. Sliding metal drawers in the refrigerator are a great convenience.

In the writer's opinion it is necessary to equip all cabinets and closets in the pharmacy with glazed doors, not only to facilitate checking of the drug supply on hand, but to facilitate access to the required medicines. Horizontal sliding doors, because they do not project into the room when

opened, have been found most satisfactory.

Should the institution be a large one where prescriptions are left for filling in the morning, it is necessary to equip one part of the pharmacy with a number of bins corresponding to the wards in the hospital wherein a prescription to that particular ward can be filed pending distribution to the ward.

If it is the intention of the hospital to provide the nurses with pharmaceutical training it is necessary to arrange sufficient floor space for this purpose.

In a small institution the interns as a rule prepare the prescriptions but in a medium-sized one it is desirable in order to maintain proper control in this department and not to have nurses and messengers passing in and out of the room to equip the door with a sliding section, the upper half of which will act as a counter and information window. In a large hospital the interior counters are arranged in such a manner as to form a vestibule, thus preventing intrusion.

#### DON'T SUBSCRIBE THROUGH FIELD AGENT

The Modern Hospital Publishing Co., Inc. has no subscription agents in the field for its publications. Renewals and new subscriptions are handled entirely through its central offices.

This statement is made after new complaints from hospital superintendents that no copies of the magazine have been received since they paid some person, representing himself as an agent of THE MODERN HOSPITAL, the price of one or more yearly subscriptions.

Latest reports on such fraudulent practices comes from the state of Georgia, where a man, giving his name as Hugh Gordon, has taken checks from several hospital superintendents and nursing supervisors. They have cancelled checks for the subscription price.

#### PUBLIC HEALTH BILLS BEFORE CONGRESS

Only 1½ per cent of the bills and resolutions introduced in the 67th Congress were concerned with national health. During the two sessions of this Congress, the first session of which convened in April, 1921, and the second session of which adjourned on September 22, 1922, over 18,000 bills and resolutions were introduced in both houses. Of this number, less than 300 pertained to public health. Five hundred and eighty-seven bills and resolutions became laws but only about 25 of these were measures of direct interest to sanitarians.

This information comes from the National Health Council which has issued thirty-six biweekly *Statements on National Health Legislation*.

## A YEAR 'ROUND HOME FOR CONVALESCENT CARE AND RECREATION

By VALERIA LANGELOTH CLARK, PRESIDENT, BOARD OF TRUSTEES, VALERIA HOME, INC., CORTLANDT, N. Y.

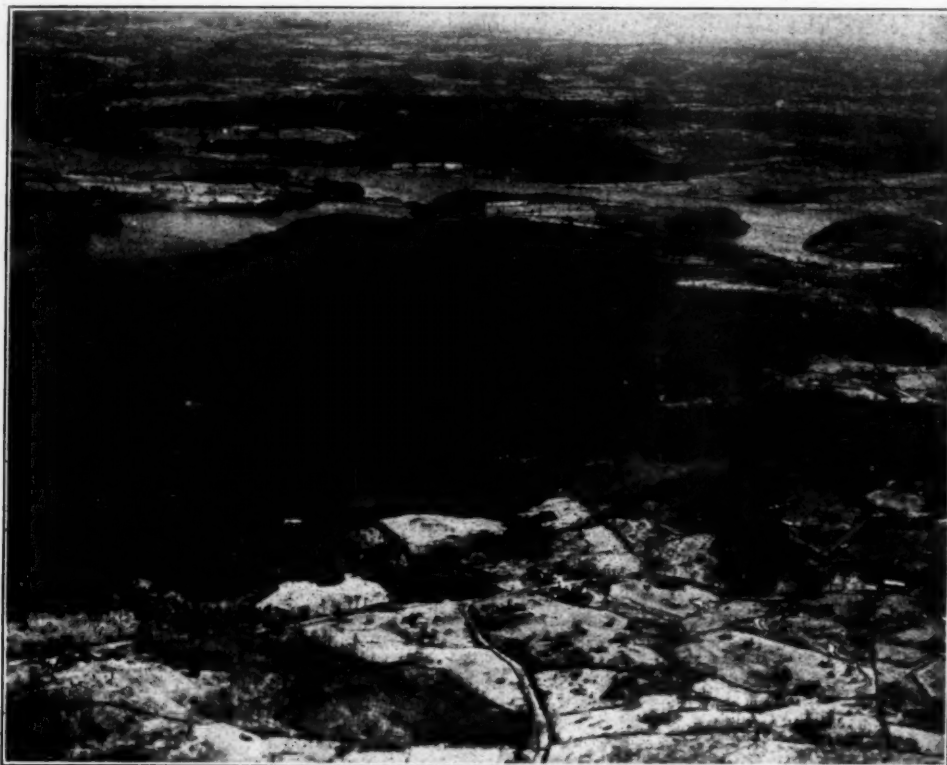
THE Valeria Home for recreation and convalescence, the origin and tentative plan of which was announced in *THE MODERN HOSPITAL* for February, 1921, as "a new idea in health conservation," is now in course of construction and a real beginning has been made in what is believed to be a new departure in institutional service. At the time the former article was written for *THE MODERN HOSPITAL* the plans for carrying out the wishes of the founder, the late Mr. Jacob Langeloth, were not fully matured, but now that actual construction has begun some further description of its architectural plan and service program is necessary in order that those interested may have a clear understanding of a social service which, in many of its features, is unique.

The Valeria Home is intended to provide year-

ing, but its rates will be kept low enough to enable any eligible man or woman to enjoy its service. All guests will be paying guests, but what they shall pay will depend upon their ability to pay. Eligibility for admission to the Home will not be restricted to the members of any racial, religious or social body or group, except that for reasons of policy, negroes will not be accepted.

### No Fixed Rule of Eligibility

The eligibility of the applicant for admission will be determined in each case after investigation of his character, ability to pay and other circumstances. No person will be accepted who is suffering from any communicable disease or any other disease or condition requiring the routine attendance of a physician or a nurse, or who, in

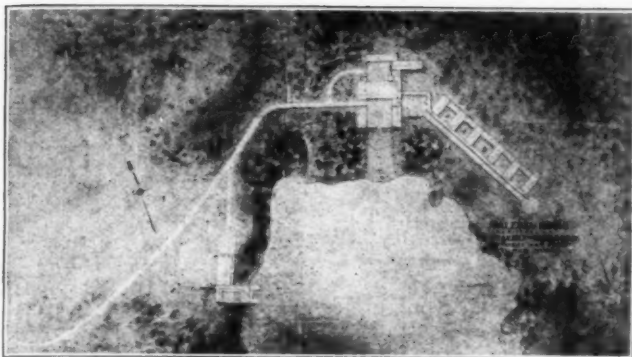


This airplane view of a portion of the Hudson valley shows in the foreground the site of Valeria Home, Westchester County, New York

round convalescent care and recreation for men and women of education and refinement who do not want or need charity, but who are unable because of small incomes to avail themselves of private sanitariums and health resorts conducted on a commercial basis. As directed by the founder the Home will be as far as possible self-support-

ing, but its rates will be kept low enough to enable any eligible man or woman to enjoy its service. Length of stay of guests will be limited but will depend upon the circumstances in each case. The Home is not intended as a permanent residence for any guest and the board of trustees has no intention of permitting it to become a home for





The general plan of Valeria Home.

chronic invalids or for the aged. The will of the founder clearly implies that promotion of the health and welfare of self-supporting, working men and women is aimed at, and while there will be no fixed rule of eligibility as to age, effort will be made to provide chiefly for persons of working age. No person under sixteen will be accepted, but the upper age limit will be determined according to need. Opportunity to enjoy the Home will not be restricted to residents of New York or its environs; any person, wherever he lives, if eligible, will be accepted.

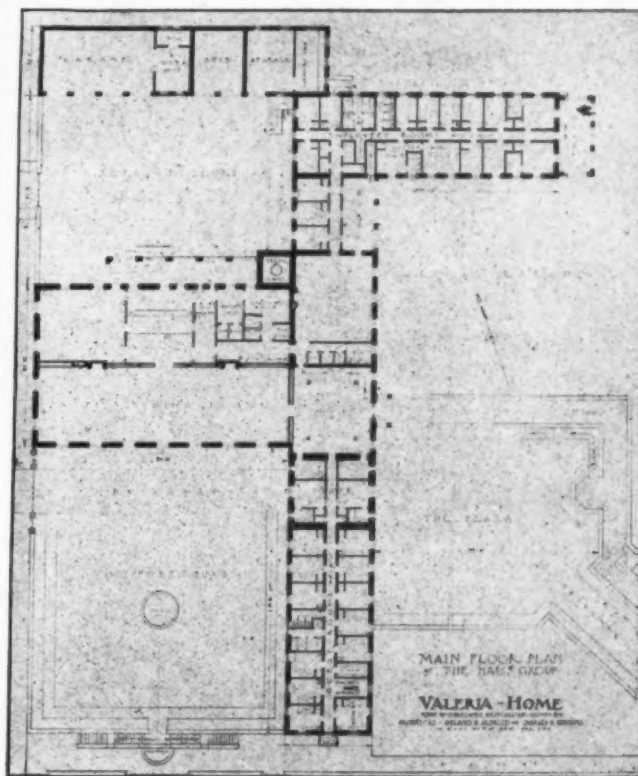
The site of the buildings now under construction was selected after careful survey of available lands in the neighborhood of New York, since it is expected that the majority of guests will be residents of that city and its vicinity. The tract of land finally purchased comprises about 1,000 acres of varied farm and woodland in the highest part of the Westchester Hills about an hour's ride from New York. The area includes two mountains, or rather hills, which are densely wooded and from the summits of which a wide stretch of the Hudson River valley can be seen. A small lake about three-quarters of a mile long and half a mile wide adds greatly to the attractiveness and usefulness of the property. Old farm lands which were run out and many acres of swamp lands have been reclaimed by thorough drainage and cultivation. The greater part of the acreage is virgin forest but there is sufficient cleared meadow land and hillside to make possible the development of all kinds of outdoor recreation both summer and winter.

#### Capitalize Natural Features

Having acquired this great area so well suited to the founder's plan, selection of a location for buildings so as to take greatest advantage of the natural features of the property was the next step. After study of all possible locations, under varying weather conditions, the south slope of Keg Mountain, shown at the extreme left in the airplane photograph, was chosen. The buildings

will, therefore, have a southerly exposure and will be protected against the north winds by the hill at their back. The lake, which has Keg Mountain at the north and Salt Hill at the east, will be immediately in front of the buildings and somewhat below them, so that guests will have a most attractive view of the water and the hills which hedge it in. The surrounding forest of oak, beech, maple and elm has been preserved and no more landscaping will be done than is necessary to give the buildings the best outlook and proper exposure to sunlight and the prevailing southwest breezes of summer. This situation of buildings seems to be ideal for year round service.

The buildings are being built entirely of native stone quarried on the site. Such selection of stone is being made as will harmonize well with the natural surroundings. Special care is being taken by the architects to avoid the coldness and rigidity which so often characterize institutional masonry, by keeping buildings low, by the use of stone of irregular shape and varied color, aged and worn in its natural setting, and by pointing up walls in such a way as to smooth and soften the joints in the masonry. The general effect aimed at is that seen in many of the early Dutch colonial homes throughout Pennsylvania, where permanence of construction, in spite of the simplicity, sometimes severity of architectural lines, gives an appearance of warmth and homelikeness not found in more modern stone buildings.



Main floor plan of The Hall group of buildings.

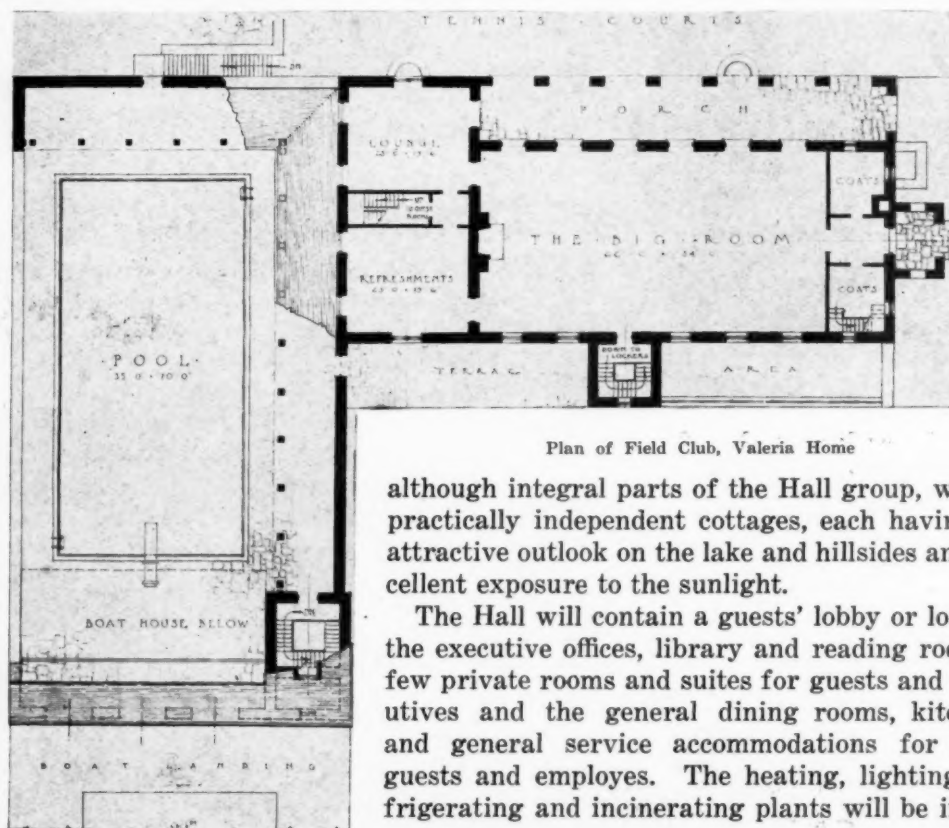
All buildings will be as nearly fireproof as it is possible to make them by means of stone, steel and reinforced concrete construction. Cement, tile and terrazzo floors will be laid wherever such non-absorptive material is desirable, as in kitchens, store rooms, laundry, garage, corridors, etc. Floors of offices, guest rooms and entertainment rooms, will be chiefly of quartered oak. All interior stairs, with the exception of the main staircase of the central hall, will be of reinforced concrete with slate treads. Partitions will be of hollow tile, and metal lath will be used throughout. The roofs of all buildings will be of slate of varied colors and irregular lengths and widths, so as to harmonize well with the natural wood tones of the hillside.

### Will Feature Rest and Recreation

The complete plan as designed by the architects and shown in the accompanying sketch, calls for three major groups of buildings, arranged in the form of a crescent, namely, a central administration and residence group called the Hall group; six guest cottages, known as the Cottages, adjacent to it on the east; and the Field Club or recreation center at the southwest and about an eighth of a mile from the central hall. The grouping and arrangement of these buildings are designed to serve as independently as may be the three major service functions of the Home, namely, food, service, rest and recreation. All food for guests and employees is to be prepared and served in the large dining rooms of the central hall, rest and quiet is to be the feature of life in the Cottages, and recreational activities are to be centered at the Field Club. The present construction plan provides only for the three cottages nearest the Hall, but the service facilities of the Hall and the Field Club can be readily expanded to meet the needs of three additional cottages as yet unauthorized by the board of trustees.

An interesting and important feature of the plan is that the Cottages and the several units of the Hall group, although apparently independent, are all connected by a broad terrace in front, underneath which is a cloistered way through which guests and employees may go in comfort from one building to another in inclement weather. A pipe gallery is also conducted beneath this terrace at a still lower level, through which will pass all lighting, heating and drainage lines, thus making maintenance and repair easy at all times. This cloister will, it is believed, add much to the comfort of guests, particularly in winter, and will at the same time make for economical operation and maintenance. Its course under the terrace will follow closely the natural contours of the hillside and will unquestionably add to the appearance of the buildings.

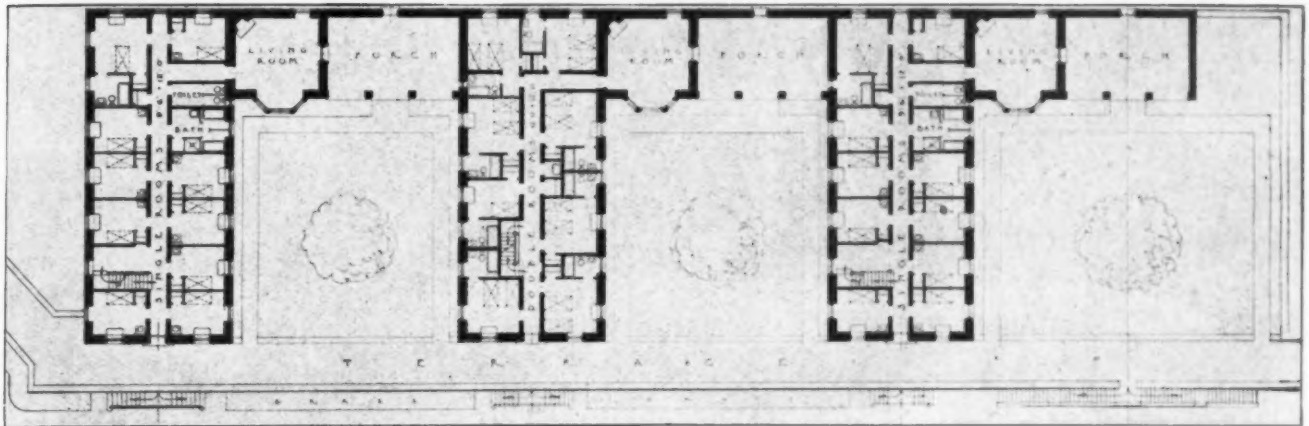
The Hall group, the main floor plan of which is exhibited, will include the hall, or major central unit, of three stories and basement, a connecting guest cottage wing of two stories and basement extending toward the lake, and a connecting employees' residence wing of three stories and basement extending to the east along the mountain side. The kitchens, storerooms, engine rooms, laundry, garage and machine shops are all accessible from a service court at the rear of the Hall and also, through the cloister previously mentioned, from the cottage group. The guest cottage wing and the employees' residence wing,



although integral parts of the Hall group, will be practically independent cottages, each having an attractive outlook on the lake and hillsides and excellent exposure to the sunlight.

The Hall will contain a guests' lobby or lounge, the executive offices, library and reading room, a few private rooms and suites for guests and executives and the general dining rooms, kitchens and general service accommodations for both guests and employees. The heating, lighting, refrigerating and incinerating plants will be in the





The main floor plan of the Valeria Home Cottages.

basement of the Hall and well below ground, so as to minimize noise. The guest cottage wing will contain only private rooms for guests and executives, and the employees' residence wing only private rooms and sitting rooms for employees other than executive officers. The residence capacity of the Hall and its two connecting cottage wings will be approximately sixty-two guests and executive officers and forty-nine domestic employees.

#### Cottages Will House 74 Guests

The cottage group, each of two stories and basement, now under construction, has been so planned as to permit segregation of the sexes as to cottages and, at the same time, reasonable freedom of social contact between them. Each cottage has its own porch and sitting room looking out upon a lawn which slopes lakeward to the terrace passing along the front of the cottages. These porches and sitting rooms serve as connecting links between adjacent cottages, but the connection will not be an obvious one because the porches and sitting rooms are only one low story in height. The effect when the cottages are viewed from below at the lake level is of independent cottages, the roofs of the connecting porches and sitting rooms not being visible. As now planned one cottage will be used for men only, one for women only and the third for married couples. This scheme of segregation is not essential, however, for satisfactory use of the cottages, as all cottage accommodations have been designed to make possible any necessary adjustment of housing to meet the need of the moment. The cottages for men only and women only will each provide accommodations for twenty guests in individual private rooms and for two guests in one double room which may, if circumstances require, be used as a house officer's residence. The cottage for married couples contains fifteen double rooms. The total capacity of the three cottages is, therefore, seventy-four guests.

The third, or Field Club group, which is situated on high open ground on the west shore of the lake and about an eighth of a mile away from the central Hall group, comprises a clubhouse of two stories and basement, with a connecting outdoor swimming pool 35' x 70' in size and a boat house on the lake edge. The club house will contain a large entertainment hall, lounge, refreshment room, game room, accommodations for four guests or executive officers, lockers, store rooms, tub and shower baths and all the usual facilities of a country club. The cleared ground about the Field Club group is well suited for tennis courts, short golf courses, lawn bowling, etc., and the lake where boating, fishing and bathing may be enjoyed is close at hand.

#### Lends Itself to Expansion

The total capacity of the Valeria Home, in the Cottages, the Hall group and the Field Club, will be 149 guests and executive officers and forty-nine domestic employees. It will be apparent to one with experience in institutional construction and operation that the service facilities, particularly those of kitchens and dining rooms, are in excess of the requirements of this number of guests and employees. It should be said, therefore, that all space and equipment has been so planned that it may be adjusted to meet conveniently and economically present needs, and may, without new construction, be readjusted satisfactorily when capacity shall be increased by the addition of more cottages. For example, the dining room space shown in the drawing of the Hall group will, for the present, be divided in half by a removable glass partition, so that that part which is adjacent to the entrance hall may be used as a general assembly or lounge.

Guest rooms, with the exception of the fifteen rooms intended for married couples and a few double rooms, designed primarily for executives, will be single rooms approximately 9'6" x 12'.



Double rooms will be approximately 12' x 12'. Effort has been made in planning rooms to have them large enough for the convenience and comfort of guests and yet so small that it will be impossible to crowd them with more than the proper number of persons. Each individual private guest room will be comfortably furnished, with ample closet room, and provided with set basins with hot and cold water. Employees' rooms will be for the most part individual rooms, approximately 8' x 12', and similarly equipped. The double rooms which have been provided for married couples and executives will have connecting private baths. An adequate number of toilets, tubs and shower baths will be provided on all floors of all buildings for the use of guests and employees.

The water supply of the Valeria Home will be obtained from deep driven artesian wells and will be ample for all possible service requirements now and in the future. A complete and thoroughly modern sewage disposal system will be installed, sufficient in size to care for all possible increases in service. The buildings will be electrically lighted and steam heated and all equipment will be of the most modern type. Farm operations, such as fruit and vegetable gardening, dairying, poultry raising, etc., will be undertaken only as experience demonstrates such operations to be necessary for the comfort and welfare of guests and an aid in the economical maintenance of the Home.

Since the Home is designed for year round service, special effort is to be made to make the winter season attractive. The lake and its surrounding hills are well situated for outdoor recreation in winter and all manner of winter sports will be developed as rapidly as possible. It is the intention of the board of trustees to pattern its winter program somewhat after that of the Lake Placid Club in the Adirondacks, which has been so successful in making its winter service quite as attractive as that of mid-summer. The Valeria Home will, however, keep in mind particularly the needs of convalescents. Few natives of New York realize the charm of winter in the country and the vacations of most workers of the group for which the Valeria Home is designed are taken in the summer. It is believed that when the plan of winter rest and recuperation has once been tried, many workers will find life in the country even more pleasant and beneficial to health in winter than in summer. It is hoped, too, that employers in many lines of business will find it possible to adjust their work so that their employees may obtain rest and recuperation when needed, whether in winter or summer.

The Valeria Home summer camp, which has been in operation for the past three summers,

will be continued for summer service during the construction of the larger buildings and, if experience warrants, will be utilized to take care of the summer overflow from the larger institution. The summer camp is an attractive two-story building with accommodations for thirty-five guests in individual rooms. Thus far only women workers have been received at the summer camp, and during the three years of summer service over 1,000 business and professional women guests have been entertained for periods varying from a few days to a month or more. The success of this service, which has been furnished at the rate of \$8.50 and \$12.00 per week, depending upon the selection of rooms, apparently indicates that no difficulty will be experienced in securing a satisfactory clientele for the larger institution. The difficulty will, we hope, be rather that of providing sufficient accommodations for all who need it and want it.

The Valeria Home represents the practical application of the ideal of the founder, Mr. Lange-loth, according to the carefully thought out plan of the board of trustees, arrived at after months of study of the needs of those for whom it is intended. Its success in meeting those will, in the last analysis, depend largely upon the cooperation of physicians and private and public health and social welfare organizations having a similar interest. The objective of the Valeria Home service is essentially the prevention rather than the cure of sickness, in other words, preventive convalescence in pleasant surroundings and, with the aid of simple natural remedies, good food, rest and recreation suited to the particular needs of the individual. No special therapeutic equipment is to be provided, and only such supervision of individual action as is necessary to make group life happy and healthful.

#### RECEIVE PRAISE FOR FIRE PROTECTION

Authorities of Mary Immaculate Hospital, Jamaica, N. Y., take pride in the safety of their building from fire hazards. In addition to a hospital building of brick and stone throughout, the institution retains the American Fire Service Corporation, of which Edward F. Croker, Jr., is the head, to conduct fire drills from time to time and to instruct all attaches of the institution in what to do in case of emergency.

The following letter from Mr. Croker, president of the company, under date of October 4, shows the high state of efficiency the hospital staff has gained.

"Desire to report that our supervising drill inspector, Capt. Charles Unbekant, visited your premises on the 2nd inst., and conducted a drill of your employees, which was entirely perfect. Signal was sent from third floor and brigade and nurses responded promptly; brigade stretched line and carried extinguisher. All placed and ready for service in 34 seconds. Nurses responded in large numbers. Splendid cooperation between Sisters, nurses and brigade."

## THE PROPER INSTITUTIONAL CARE FOR PATIENTS WITH CHRONIC DISEASES

By ERNST P. BOAS, M.D., MEDICAL DIRECTOR, MONTEFIORE HOSPITAL FOR CHRONIC DISEASES, NEW YORK, N. Y.

THE problem of the hospital care of the patient suffering from chronic or so-called incurable diseases has barely been touched upon, in spite of the great progress that has been made in the standards of the general hospitals within the last thirty years. The reasons for this fact are manifold, and it shall be my endeavor in this article to stress the important factors involved in the care of chronic patients and to suggest a partial solution of the problem.

It will be well to define what is meant by the chronic patient. In short, he may be described as one who requires hospital care for a period of from three months to several years. The reason for his prolonged hospitalization may be medical or chronic. In many diseases the complete or partial rehabilitation of the patient may require months of treatment. Furthermore, there are many patients rendered helpless by their disease, who need skilled nursing care but little medical attention, who cannot be taken care of in their homes because of unfavorable home surroundings. Finally, there are those disabled by some ailment who require no expert treatment but who are homeless. The following are

among the most important diseases which may compel a patient to seek institutional care: organic disease of the heart, arteries or kidneys, chronic arthritis, diabetes mellitus, carcinoma, hemiplegia, organic nervous disease of all kinds.

There is another phase of the problem that is very important. Seventy years ago the so-called "chronic diseases" caused about one-fifteenth of the total number of deaths. Today they are responsible for one-half of all deaths. Scientific study of these diseases can be pursued only in an institution and is urgently needed. It offers probably the most fruitful field of research dur-

ing the coming years. It becomes the duty therefore of every institution that cares for the chronic sick not alone to harbor these unfortunates after the disease has run its course, but also to be equipped to study the causes of the chronic ailments of mankind with a view to prevention.

A little reflection will call to mind how great is the number of individuals who are incapacitated by such diseases and how vast is the problem of their proper institutional care. On June 30, 1920, of the 9,107 patients in county, state and town almshouses in New York, 59.1 per cent

were sick or infirm, 23.3 per cent able-bodied, and the rest either blind, deaf, feeble-minded or epileptic.

In the past most of the chronic sick have drifted into almshouses, together with the aged and paupers, where there are few facilities for their proper care. It is true that within the past fifty years hospital wards have been established in connection with most almshouses, and that many homes for incurables have been founded, but they too have been and are, for the most part, purely custodial in nature and have done little more than provide for

*"One-half of the deaths in the community are attributable to chronic diseases. The scientific investigation of these diseases and the adequate care of those afflicted with such ailments is one of the crying needs of the time. More hospitals for chronic disease, which will admit patients for periods of from three months to several years, should be established. Such hospitals must be equipped with all of the facilities of a general hospital. They should retain in their wards only such patients who need active medical and nursing care. In connection with such hospitals there should be a separate pavilion for purely custodial cases. A method of free transfer between the two departments of the institution should be established. A home for incurables should have no independent existence without immediate access to complete hospital facilities."—DR. BOAS.*

the most elementary needs of these invalids who wait for death to release them from their miseries.

The problem of the proper care for these unfortunates is an old and a perennial one. In 1884 the New York State Charities Aid recommended that no feeble, intemperate or unqualified person should be allowed to nurse the sick, and that at least one good nurse be employed in every poor house. In the same year a training school for nurses was established at the Blockley Almshouse in Philadelphia. Yet, in 1919, in the report of the State Board of Charities of the State of New York, we find the statement: "Such complaints



show that the superintendents of these homes for the aged and infirm need the assistance of competent and conscientious nurses, orderlies and other attendants, that the dependent wards of the city may be assured adequate care."

In England the development has been much the same. An order of the poor law commissioners in 1847 states that "any able-bodied woman or girl might be employed constantly or occasionally in any of the female sick wards; and any infirm woman, whom the master of the workhouse might deem fit to perform any of the duties of nurse, might be so employed in any of the female sick wards; any male infirm inmate, whom the master might deem fit, being likewise employed in the male sick wards." Some years later the inadequacy of such provisions was realized and the Workhouse Infirmary Nursing Association secured radical improvements in this respect and between the years 1879 and 1889 supplied 92 trained nurses to different infirmaries. Even before this, in 1865, Miss Agnes Jones and twelve nurses from St. Thomas' Hospital undertook the nursing at the Liverpool Workhouse Infirmary and became pioneers in the scientific nursing of sick paupers.

#### Ice Cream in Place of Medical Treatment

At the present time, as I shall endeavor to show in a survey to be published later, very few of the institutions devoted to the care of sufferers from chronic diseases have the organization and equipment to carry on their work properly. In most of them the staff of physicians and trained nurses is very inadequate, laboratory facilities are lacking, and the policy of the institution is not guided by a medical and community point of view. A lady board of managers, with little appreciation of medical problems, guides the destinies of too many of these homes. The result of such an administration is found in the great attention that is paid to ice cream treats and amusements for patients, and the scant consideration that is given to important medical policies.

The slow progress in providing adequate care for incurables and for those suffering from chronic ailments is due largely to misconceptions as to the nature of their diseases and as to the treatment which they require. From the point of view of institutional care these patients may be grouped into three classes:

Class A. Those requiring medical study for diagnosis and treatment.

Class B. Those requiring nursing care only.

Class C. Those requiring custodial care only.

The management of each of these groups is a problem in itself and each class places different demands on the institutional resources. To clarify

this point it may be well to cite a few examples of cases which fall into the different categories.

Thus, a patient with advanced organic heart or kidney disease, who may require many months of hospitalization, or a patient with an inoperable carcinoma, which may still yield symptomatically to proper treatment with x-ray and radium, falls in Class A. All of the facilities of a general hospital are needed to give adequate care to such patients. A patient with paralysis of both lower extremities, due to some incurable process involving the spinal cord, needs little medical treatment but requires careful nursing. In the same group fall the senile patients who are incontinent and who are, in other ways, unable to serve themselves. These patients fall in Class B. It is not enough to provide them with partially trained attendants. Their nursing must be painstaking and skilled to prevent bedsores and other complications. Catheterization and other technical nursing procedures are often demanded; the onset of pneumonia or some other complication must be watched for. Finally, in the custodial group must be classed patients with early multiple sclerosis, paralysis agitans, compensated heart disease or some other affection which is not completely disabling. They do not demand expert nursing. Sympathetic attendants under skilled supervision are adequate to provide them with proper care.

A most important fact to recognize is that patients do not remain in one class indefinitely. Thus a patient may be admitted in Class A and in the course of months improve sufficiently to become a purely custodial case. This happens very frequently. On the other hand, it is just as common for a patient in Class B or in Class C to develop some complication or exacerbation of his illness which puts him into Class A. The fact cannot be overemphasized that the type of treatment demanded by the different groups varies considerably. The proper care of a Class A patient demands a complete hospital organization with a resident staff, an attending staff on which all of the specialties are represented, complete laboratory, x-ray and operating room equipment and skilled nursing and dietetic management. Class B patients require much less specialized attention but should command an excellent nursing service, controlled by a conscientious medical staff. Class C patients need the least care. As the classification implies, their treatment is largely custodial in character and they are retained in an institution not because they require hospital care but because the economic surroundings at home are such that they cannot be taken care of by their families. All of their wants are supplied by proper sleeping and living accommodations and food, with due regard to their respective dis-



abilities. Thus, many will require wheel chairs and all of the structural institutional facilities that that implies, and many will need the assistance of attendants in dressing, bathing and eating.

At the present time most "incurables" and patients with chronic diseases are taken care of in municipal institutions or in private homes for incurables. The municipal institutions largely partake of the nature of homes and derive their patients from the municipal and general hospitals, which transfer to them patients whose hospitalization is prolonged and who no longer interest them. Many of these still are Class A or B patients, yet the vast majority of the institutions which receive them are not prepared to care for them properly. A patient, once admitted to such a home, vegetates there until he dies and little or no attempt at rehabilitation is made. This may be readily ascertained by a comparison between the per capita cost of such an institution and of a general hospital. It should cost almost as much to give adequate service to Class A and Class B chronic patients as to patients with acute conditions. On the other hand, it is a wanton waste of funds to care for a custodial case in an institution which is equipped to handle the sicker type of case.

### Evolution of Chronic Disease Hospitals

It may make matters clearer to consider the historical development of a hypothetical hospital for chronic diseases. It has been founded years ago by well-meaning philanthropists to provide a permanent home for a group of invalids whose miserable home surroundings make their institutional care necessary. Every case is carefully investigated before admission by a committee of the directors and personal contact is kept with the patient after his admission to the home. It is the social and economic aspect of the case which is the predominating one. A doctor is appointed as visiting or resident physician to the home. If he is at all conscientious he finds that many of the inmates present very interesting and difficult medical problems which he cannot handle alone. On his recommendation, more physicians are added to the staff. The medical staff devotes more and more time to the institution and makes ever increasing demands on the directors. As the patients are more carefully studied, accurate medical records must be kept, a laboratory must be established for routine diagnosis, an x-ray department is found necessary, and so the development goes on in all phases of the hospital's activities.

At first the patients were cared for by attendants or practical nurses, possibly under the direction of a graduate nurse. As the medical activi-

ties of the institution expand, more competent nursing service is demanded and more and more graduate nurses are employed. With a wide-awake board of directors and an active medical staff, the institution, which started as a simple custodial home for incurables, develops in a few decades into a highly organized hospital which is capable of handling all of the diagnostic and therapeutic procedures that are employed in a general hospital. The institution has learned that although this is expensive, it is the only safeguard against the maltreatment of patients. If a patient suffering from a chronic disease develops pneumonia, as happens so often, the institution must provide him with expert nursing and medical care. Many a hemiplegic and many a patient with arthritis deformans, who is bedridden, can be made to walk if given the proper mechano-therapeutic treatment. Occasionally it happens that the doctors discover that some patient, admitted as a paralytic, has a spinal cord tumor or a brain tumor and that an operation will relieve these symptoms and restore him to health. It is bad psychology and bad medical practice to call a patient "incurable." It results inevitably in sloppy treatment and neglect, and takes for granted more knowledge than a physician has a right to arrogate to himself.

Let us imagine that an institution which cares for chronic patients has passed through the development sketched above. It has all of the facilities of a general hospital adapted, however, to the particular needs of its patients. When we analyze the type of patient in such an institution, we find inevitably that although there are many patients who fall in our Class A and B, who require this expensive care, there are others who belong to the purely custodial class. It is a waste of funds to house such custodial cases in a costly hospital plant, for they do not need intensive medical and nursing care, they do not need the other resources of the institution, such as the laboratories and the other special departments. Their need is primarily economic. They require a home, yet, before they can safely be classed as custodial cases, they will require careful study and the use of all of the facilities that the institution has at its command. After they have been declared custodial cases, they may at any time develop an acute complication which renders skilled medical and nursing service imperative.

### Separate Building for Custodial Cases

They should therefore be housed in a separate building especially designed for their care, where they can be made comfortable and cared for at a minimum expense. The main institution should be reserved for patients who require the special-

ized facilities of a hospital, and for whom there is some hope of rehabilitation. In charge of the building which houses the custodial cases there should be an experienced graduate nurse and a physician from the main institution should visit the home periodically. A free method of transfer between the main institution and the home should be established. When a custodial case becomes ill, he should at once be returned to the main institution. When a patient in the main institution no longer requires special hospital care and cannot be discharged because of his poor home surroundings, he should be transferred to the custodial institution. No patient should be admitted directly as a custodial case without first having passed through the careful routine of the hospital. Such an organization will avoid the evils which are inevitably bound up with the present homes for incurables and will, at the same time, avoid the unnecessary expense of maintaining custodial cases in an institution designed for the care of hospital patients.

#### TUBERCULOSIS TRAINING FOR NURSES

It is small wonder that so many nurses are afraid to come near or give attention to a case of tuberculosis.

Many studies have been made to show that the average nurse, like the average doctor, gets little real knowledge of tuberculosis from first-hand contact during her two or three years of training. It is only by actual experience and training in tuberculosis work that the fear of the disease is overcome and the methods of protecting one's self and others really mastered. No one is so fearful of tuberculosis as the person who has never been inside a sanatorium. Additional light on this problem has been thrown by a recent study of training schools in New Jersey made by Miss Virginia M. Chetwood.

Miss Chetwood received replies from 26 of the leading hospital training schools in the state in response to a questionnaire that she had sent out. Only one school of the entire 26 gives any regular ward training in the care of tuberculosis to its nurses. Eight of the 26 never receive any cases of tuberculosis, refusing them admission to the hospital. In seven of the schools a certain amount of clinic service ranging from four to eight weeks is given. Seventeen of the 26 give lectures on tuberculosis, the remaining nine giving no instruction either by word of mouth or by clinical demonstration to any of its nurse pupils. In only five cases were lectures given by physicians competently trained in tuberculosis. Only 11 of the training schools were willing to affiliate with nearby tuberculosis sanatoriums for the training of their pupils nurses, although in 18 instances such institutions were in close proximity. Of the 15 who were unwilling to make such affiliation 8 of them gave as a reason that they were short of nurses.

It is a sad commentary upon nursing education that hundreds, nay even thousands of young women, are graduated apparently as full-fledged nurses every year without any practical knowledge of tuberculosis, the most prevalent and dangerous disease in the country. It is disheartening to note the attitude of managers of such training schools in refusing to avail themselves of ready-made facilities for training nurses because of the expense involved.

It is to be hoped that as the result of the Rockefeller Foundation study of nurses training schools those institutions that refuse to train nurses as they should be trained will be compelled by public demand to find some other way of getting their nursing done. It is high time that our training schools for nurses were taken out of the category of agencies that exploit their pupils for pecuniary advantage.—*Journal of Outdoor Life*.

#### STANDARDIZING CLINICAL LABORATORIES

Four general standard requirements for clinical laboratories are enumerated by Dr. Josiah J. Moore of Chicago, in an address on "Standardization of Clinical Laboratories" delivered before the section on pathology and physiology at the last annual session of the American Medical Association. The paper is published in a recent issue of the *Journal of the American Medical Association*.

These requirements represent Dr. Moore's own thought on the subject and the suggestions of a large number of laboratory directors and pathologists to whom they were submitted. As enumerated they are:

1. The director of a clinical laboratory should be a medical graduate.
2. All interpretations of laboratory data should be made by doctors (of medicine, philosophy or public health) who are specialists in the branch of work to which the data pertain, i. e.:
  - (a) Serologic, bacteriologic and chemical interpretations should be made by doctors who are trained serologists, bacteriologists and chemists.
  - (b) Tissue diagnosis should be made by doctors of medicine who are experienced pathologists.
3. Technical procedures (methods) used in an acceptable laboratory should be the best available: those used and approved by authorities.
4. The equipment of an acceptable laboratory should be such that the proper technical procedures may be carried out. There should be ready access to current scientific books and journals.

With reference to these suggested requirements, the following statement is made:

1. The director of a laboratory should be able to act as consultant in evaluating for his clients the various laboratory reports and in correlating them and other clinical data.
2. Many technical methods—most of them, perhaps—may be satisfactorily carried out by technicians. The data derived by such methods, however, should be interpreted by specialists.
3. If it is insisted that only the best modern methods be used in a laboratory, it follows that the technicians employed must be trained in these methods.
4. Clinical data and other pertinent information should accompany the submission of specimens or other material to the laboratory.

As the methods of standardizing clinical laboratories, Dr. Moore mentions several agencies, none of which pleases him. His general conclusion is that a combination of such agencies should undertake the work.

A method of state control of public health could be adopted in each state, but there would surely arise the same difficulties we now have with the multiplication of state boards of medical examiners.

A more general system of supervision appears desirable, and this may be accomplished by having the hygiene laboratory of the U. S. Public Health Service act as a central authorized body.



## HOSPITALS OF COLOMBIA

BY JORGE CAVELIER, M.D., CHICAGO, FORMERLY OF BOGOTA, COLUMBIA.

A STUDY of the hospitals of Colombia ought to include not only the description of those institutions that exist at present, but a consideration of the projects that today are developing in conformity with advanced medical science. What these hospitals will be in the near future depends on the economic development of Colombia.

In this article we will study three phases of hospital conditions and what is said here will apply to all the hospitals of the republic as almost all of them are confronted with the same problems.

There are two classes of hospitals in Colombia, those which are organized and maintained by the government and those organized by individuals who give their services to society and at the same time ask some remuneration from patients.

The first class, or the public hospitals, at all times receive some donations from charitable persons who wish to contribute to the betterment of these establishments. The Hospital de la Misericordia (Mercy Hospital) of Bogota will serve very well as an example. The building was bequeathed by Dr. Ignacio Barberi for the treatment of children's diseases and the government pays for the current expenses of keeping it up. There are many such cases as this.

pital) of Medellin, etc. The department governments or the municipal governments maintain them but the national government contributes considerable amounts of money for the running expenses of many. Administration generally is by a board known as "Junta de Beneficencia" (public welfare board) which is composed of persons of wide reputation who donate their services.

The buildings which the charity hospitals now occupy are inadequate; the majority of them are similar in construction, having been built during the Spanish colonial period. It is impossible in many instances to change or remodel details to conform with the present rules of hygiene, and the only remedy is to build entirely new buildings.

The Charity Hospital of Bogota, called San Juan de Dios, has undergone various changes lately which have improved its hygienic and esthetic conditions. It now has wards for gynecology and maternity cases, which fill that need fairly well, but it also is of Spanish construction and does not meet with the requirements of a modern institution.

As to the equipment of these hospitals, it is far from satisfactory; only a few of them possess the instruments and apparatus needed for the prac-



A sanitary station at the port of Colombia.

Public hospitals are known as "Hospitales de Caridad" (charity hospitals) and can be found in every city and town of Colombia, generally under some such name as "Hospital de San Juan de Dios" (Saint John of God Hospital) of Bogota, "Hospital de San Vincente" (Saint Vincent's Hos-

tice of the various specialties into which modern medicine and surgery are divided. The "Hospital de San Juan de Dios" of Bogota has complete x-ray equipment; naturally it makes the hospitals in other cities of Colombia realize the importance of such apparatus.



These hospitals for the most part must receive patients with every kind of disease; a few of them located in the principal cities are dedicated to a single specialty only. For instance in Bogota there are the "Hospital de los Alisos" for the treatment of smallpox and "Hospital Misericordia (Mercy Hospital) for children's diseases. The Hospital for Mental Diseases, which also is in Bogota, has separate buildings for men and women and is known as "Asilo de locos y Asilo



Hospital de San Juan de Dios at Cucuta.

de locos" (Insane Asylum for Men and Women). There is also in Medellin an institution for mental cases only.

In the various departments, there are what is called "Dispensarios" (dispensaries) which are devoted to the prevention of venereal diseases by administering the proper treatments in these cases. The most important of these are "Dispensario de Cundinamarca" (Cundinamarca dispensary) which is located in Bogota; "Dispensario de Girardot" (Girardot dispensary) in the city of Girardot, and the dispensaries of the cities of Medellin, Cartagena, and Cali. Bogota also has a municipal clinic for venereal diseases which is maintained by the municipal government.

The national government maintains for the treatment of leprosy three leper colonies, where are isolated all those afflicted with that disease. They are known as "Leprosario de Agua de Dios" of Cundinamarca, "Leprosario de Cano de Loro" (Cano de Loro leper colony) in the department of Bolivar and Leprosario de Contratación in the department of Santander. Each one of these colonies attends the sick free of charge. Their administration is under the "Direccion General de Lazaretos" which has its offices in Bogota. At present Dr. Alejandro Herrera Restrepo is in charge of it.

There are institutions called asylums for old people and for the development of the abnormal in the principal cities; for instance the Old People's Asylum in Bogota, the Asylum for the Poor of the same city, and many similar institutions in Medellin, Cartagena and others.

These public institutions are under the management of a board of citizens, known as the "Junta de Beneficencia" (public welfare board), and they are empowered by the government to decide on all questions which may come before them regarding free hospital service. In Bogota all these municipal institutions are under the direction of the "Junta General de Beneficencia de Cundinamarca" (general public welfare board of Cundinamarca) which is in full charge of all matters pertaining to the general management and president of which now is Dr. Francisco Samper Madrid.

### Private Hospitals Are Called Clinics

Regarding the private hospitals which are found in many cities of Colombia and are owned by physicians or companies, patients are required to pay for the attention received there. They are generally called clinics or "Casa de Salud" (health homes) and a few of them are called hospitals.

In Bogota, the following are of that class: the well-known Dr. Pompilio Martinez' Clinica Quirurgica (surgical clinic) which has recently been built in accordance with all modern requirements, and where only surgical cases are received; the Casa de Salud de Marly (Marly health home) located in the suburbs of Bogota, where both surgical and medical cases are treated, its head physician is the notable Dr. Carlos Esguerra, and its surgeon, Dr. Zoilo Cuellar Duran; the Clinica de Santa Lucia (St. Lucy's Clinic) maintained by Dr. Manuel Antonio Cuellar Duran, where only eye, ear, nose and throat diseases are treated. Next to this latter clinic, there is a pavilion for gynecology cases treated by the celebrated specialist of Bogota, Dr. Rafael Ucros; Dr. Manuel V. Pena's "Casa de Salud" (health home) is located in the center of the city and is for patients who need surgical and medical attention; the "Casa de Salud del Campito" maintained by the Sisters of Charity is devoted to the treatment of mental and surgical cases.

The other cities of Colombia also have private institutions, such as: the "La Samaritana" (The Samaritan) of Medellin, which is conducted by Dr. Montoya y Florez; Dr. Luis Garces' Clinic in the city of Cali; the Doctors Gomez Sanchez and Lemus y Rodriguez' Clinic and Dr. Calvós Casa de Salud in Barranquilla; the Casa de Salud which has just been opened in Cartagena by some of the best physicians of that city, together with a United States physician, Dr. Pernet y Cordoba as the principal organizer. In Cumbre, a town in Valle del Cauca near the city of Cali, there has been for some time, a sanitarium maintained by United States physicians.

Dr. Julio Zuluaga has just opened his clinic in Manizales; the United Fruit Company has constructed a modern hospital along American lines in the city of Santa Marta and it is for the use of the laborers in the banana zone who may wish to go there. The Tropical Oil Company recently built a hospital in the town of Barrancabermeja in the department of Santander which is for the use of its employes in the petroleum fields.

### Equipment Conditions Vary

The condition of these private hospitals, as to the buildings they occupy and the equipment they have, varies. Some of them have been recently built on the general plan of a hospital adhering to the rules of hygiene, and offer all the modern conveniences, such as Dr. Pompilio Martinez' "Clinica Quirurgica" (surgical clinic) in Bogota; Dr. Calvós "Casa de Salud" in Barranquilla; the United Fruit Company Hospital in Santa Marta and others. The rest have utilized buildings not especially constructed for hospitals, but having been remodeled, they are able to give fairly good service. As to the equipment, some are completely outfitted with all apparatus and instruments for examining and treating all classes of diseases, but there are others which are very deficient in this regard. The proprietors realizing their lack try hard to acquire all necessary equipment that up-to-date medical science demands. We will find in all the cities and towns of Colombia that the people have come to realize that the possession of hospitals which comply with the principles of hygiene and have all the known modern instruments and equipment for the diagnosis and treatment of all diseases, not only ought to be, but are a real necessity in the 20th century. Unfortunately the economic situation of the country does not permit us to advance in this work as rapidly as one would like. However, the country is now beginning to give freedom to its energies and is giving some of its wealth to institutions which care for those in need. Considering the bad situation of the country great projects have advanced as the result of the individual and government initiative.

### Surgical Society Builds Modern Hospital

As the reader can appreciate, after having read the previous paragraphs, there is not a large modern hospital in the city of Bogota, the capital of Colombia, but two are now nearing completion. Colombia hopes in these two to have her first thoroughly up-to-date hospitals. One of these two institutions is a result of the efforts of the "Sociedad de Cirugia" (surgical society) of Bogota and the other has been built at the instigation of the

"Junta General de Benèficencia" (general welfare board) of Cundinamarca. The two hospitals are intended to be charity hospitals and replace the present charity hospital, San Juan de Dios.

The "Sociedad de Cirugia" (surgical society) of Bogota is an association of a scientific nature and is composed of the most renowned physicians of the country. It was organized for the purpose of building a hospital, with a rather large capacity on the pavilion plan, pavilions for different diseases being completely separated, but all opening on a central pavilion. All the most modern conveniences are found there and all in accordance with the rules of hygiene. There are various operating rooms and it has the services indispensable for the correct practice of medicine and surgery, such as x-ray laboratories, bacteriological laboratories, etc.

The "Junta General de Benèficiencia" (general public welfare board) of Cundinamarca, with offices in Bogota, has started to build a hospital of large capacity for the purpose of replacing the present Hospital de San Juan de Dios. It will be known under the same name, "San Juan de Dios."

With these two public hospitals both of a large capacity, Bogota which has a population of 200,000 inhabitants will be sufficiently provided with such institutions for the present.

Colombia is a country endowed with enormous natural wealth. In its soil are found the richest emerald mines of the world, gold, silver, copper, iron and many other minerals. Platinum is extracted in large quantities in the Choco region; there is petroleum in all parts of the country, and a great part of the territory produces coffee, cocoa, bananas and many other food products.

Besides its position on the Panama Canal, Colombia has both Atlantic and Pacific ocean coasts, making its location enviable for the development of its wealth and the exporting of it, at little cost to all parts of the world. Unfortunately its wealth has been unexplored and it is only now that some companies have begun to develop and are supported by either national or foreign capital; both together are placing Colombia in an economic position truly enviable.

The approbation of the treaty with the United States by which Colombia will receive the amount of \$25,000,000 will be another means for Colombia to prosper and consequently to increase the wealth of its inhabitants. With the economic perspective of Colombia so brilliant, it is natural to suppose that the construction of modern hospitals and their equipment will be called to the attention not only of the government, but also of individuals. Even today they are taking great interest in this subject.

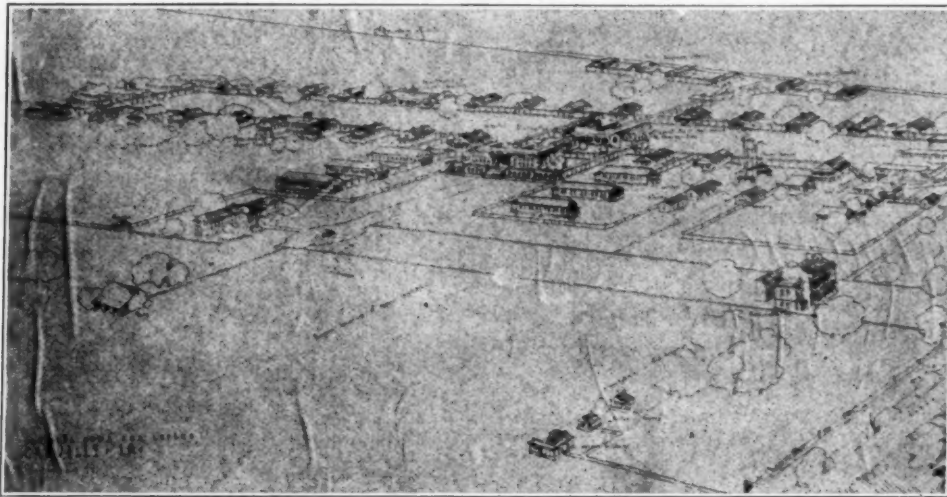


## THE ONLY NATIONAL LEPROSARIUM IN THE CONTINENTAL UNITED STATES\*

By C. H. LAVINDER, M.D., SURGEON IN CHARGE, U. S. MARINE HOSPITAL, No. 21, NEW YORK (STAPLETON), N. Y.

**E**FFORT on the part of those interested in lepers to have established in the United States a national leprosarium for the care of these unfortunates culminated during 1917 in the passage of legislation on the part of Con-

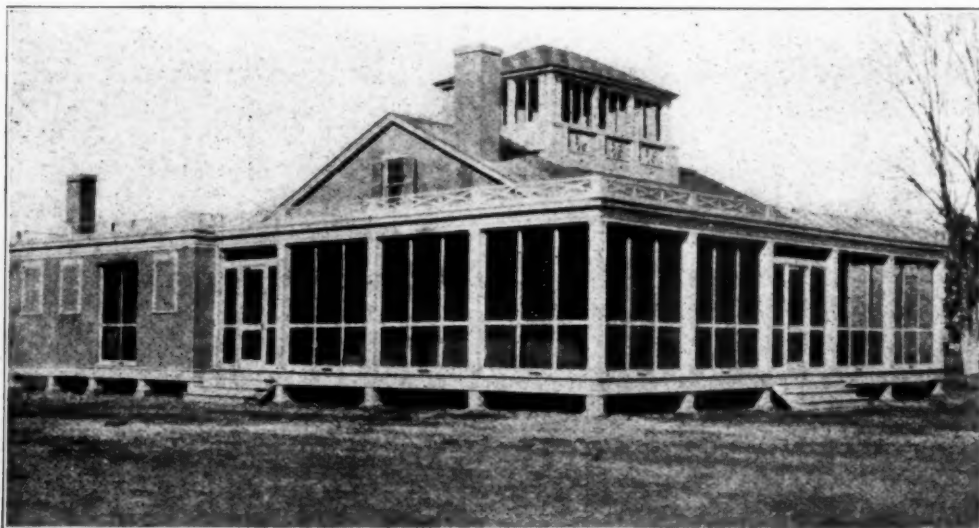
cation for this place. Difficulties of all kinds were encountered, chiefly strenuous objection on the part of any locality to the existence of such an institution within its borders. Finally, after nearly three years of effort, negotiations were



A drawing of the national leprosarium at Carville, La., as it is planned eventually to accommodate 500 lepers.

gress, appropriating the necessary funds for the establishment of such a place. This leprosarium, in accordance with the legislation, was to be operated by the United States Public Health Service.

completed with the state of Louisiana to purchase a state leprosarium, which had been in operation many years at Carville. The title of this place was finally transferred to the United States gov-



Frame-stucco quarters recently erected for the medical officer in charge.

Subsequent to the passage of this legislation, there followed an earnest search on the part of the Public Health Service to find a suitable lo-

vernment in 1920. At that time, there were in this institution eighty lepers.

The legislation carried a total appropriation of \$250,000. As soon as the title to the place had

\*Approved for publication by the U. S. Public Health Service.



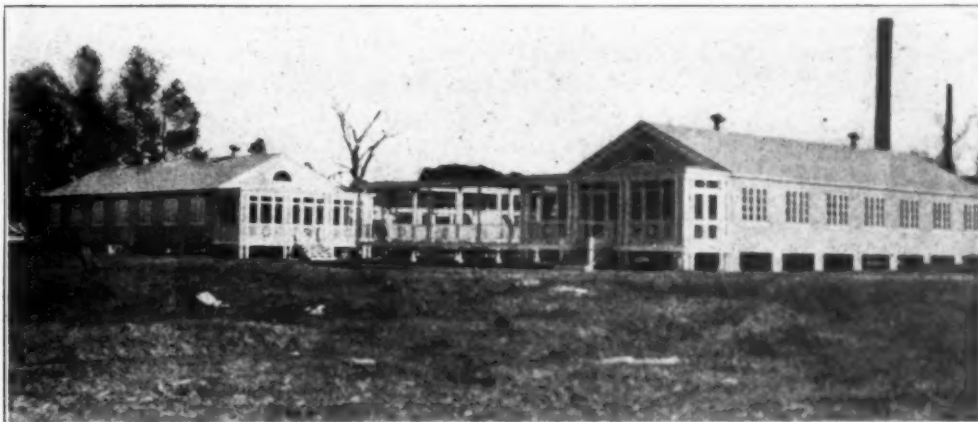
passed to the national government, the Public Health Service immediately undertook to expend this money in improving the place and extending its facilities, with the result that there is now available a total of about 200 beds.

The establishment of a national leprosarium in the continental United States

is a matter of some significance in public health. It is not known how many cases of this disease exist on the continent. Various estimates have been made, ranging from 500 to 1,200. The probability is that somewhere between these extremes will be found the truth.

Leprosy, as is well known, is an ancient disease characterized by marked chronicity, with many repulsive features, and, since the days of Moses, has borne a sinister reputation in the lay mind. It is curable with difficulty and there exists need of prolonged care, since the average duration of this disease is many years. Cures do take place, however, and patients from leprosariums are frequently admitted to parole, while under observation, for two years or more.

Leprosy is an infectious disease, the specific organism being well known. Its method of spread is uncertain. It is well known however that the disease, once introduced into a community, does slowly spread involving after many years not a few of those persons who come into intimate contact with others afflicted with this infection. It has also been shown, as would be expected in a disease of this character, that careful collection and segregation of all the infected ultimately results in the disappearance of the dis-



The patients' quarters at the national leprosarium.

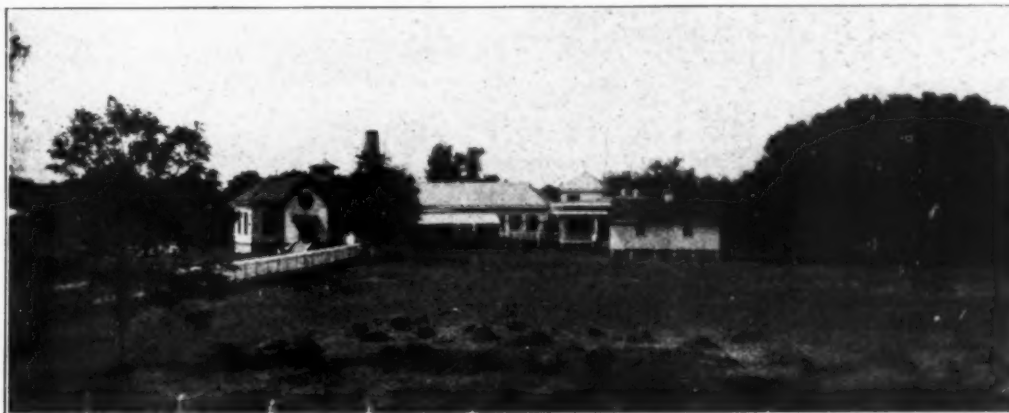
ease from the country where such precautions are properly carried out.

### Disease Advances Slowly But Steadily

Of course, in mere numbers leprosy from a public health point of view is almost a negligible quantity, at least so far as the United States is concerned. This statement, however, is true only for the present time. Should a disease of this character be permitted slowly to progress, no one can doubt that with the passing years leprosy, even in the United States, may become a question of serious public health importance. Its history in other countries has always shown a slow but steady advance. Of course, it should also be recognized that certain races appear to possess a relatively high degree of immunity to this disease, but the United States now harbors so many people belonging to almost all the races of the world that this particular point is a matter of comparative insignificance.

From every point of view, it is certainly the duty of this government to put into effect a policy with regard to this disease which ultimately will result in its disappearance, and this has been begun by the establishment of a national leprosarium where these sufferers can be placed in congenial and humane surroundings without endangering the health of this country.

The leprosarium, which has been established at Carville under the Public Health Service, is known as United States Public Health Service Hospital No. 66. It has an extent of 380 acres.



The hospital grounds, as seen from the levee of the Mississippi River.

It is located on the Mississippi River about 100 miles northwest of New Orleans and near St. Gabriel. The buildings which existed when the place was transferred to the national government have been remodeled and the place has been laid out on a plan which contemplates future develop-

In the housing of the patients, experience has shown that it is far better to arrange for their housing in small groups, where persons of congenial temperament may be brought together. The new construction, therefore, will be found to consist of cottages caring for ten to fifteen peo-



The administration building at Carville.

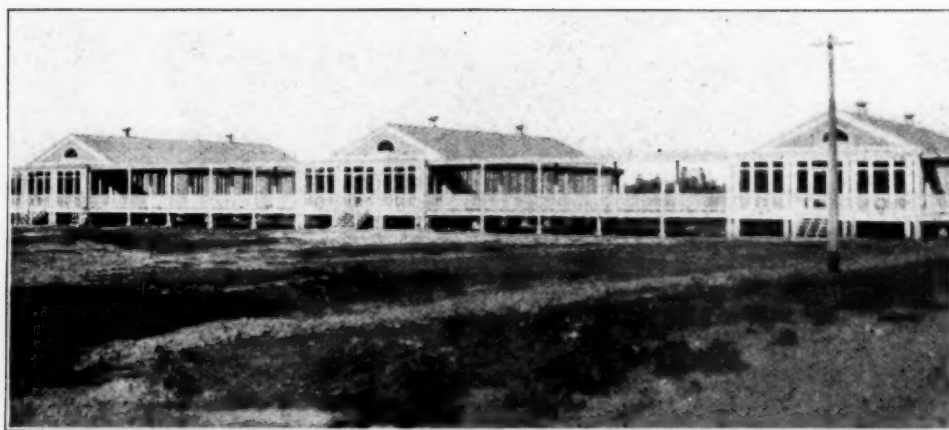
ments. Several additional structures have been erected giving a total bed capacity of 200. Arrangements are made for the reception of both sexes, and for colored as well as white. Care has been taken to provide for the necessary housing and care of all patients. Of course, professional facilities have also been take care of and considerable attention has been devoted to the provision for recreational facilities. The religious tendencies of the patients have not been overlooked.

By reason of the long duration of this disease, such patients while under treatment are not so well cared for in ordinary hospital wards. The problem becomes one of combined domiciliary

ple rather than large dormitories. Photographs and sketches will show the general layout of the institution and the character of the new construction.

The medical officer in charge of this institution is Dr. O. E. Denney, a reserve officer of the Public Health Service, who has had long experience in the care of lepers in the Philippine Islands, where there exists one of the largest leprosariums in the world. The collection of personnel for a place of this kind is by no means easy, since it involves more or less isolation and constant daily touch with persons who are suffering from what is, in many instances, really a loathsome disease.

It should be understood that the lot of lepers,



Some newly constructed cottages for lepers.

care and hospital treatment in the case of acute exacerbations or intercurrent illnesses, and the necessary infirmary is provided for these. The general treatment of the disease can be carried on quite satisfactorily without the necessity of actual hospitalization.

if segregated singly or in small groups, is undoubtedly very harsh. When they are congregated, as in a leprosarium of this character, in larger groups, surrounded by good living conditions and treated with a broad humanitarian spirit, their lot becomes far less harsh, if not



actually comfortable and sometimes even happy. The spirit which exists among the inmates of this institution is excellent, and, if one were to visit the place, one would find a rather happy family living comparatively normal lives and indulging in useful labor and healthful recreation. This is the spirit, of course, which must characterize a place of this kind, if it be a success.

It is of interest to note that in the legislation establishing the national leprosarium it is also provided that the national government should undertake the collection and transportation of lepers and pay the expenditures involved. This is a point of some significance in view of the difficulties presented in the transportation of persons suffering from this disease, on account of certain laws and of the popular feeling in the lay mind concerning the possibility of the ready transmission of this and other infections. This makes necessary always special arrangements to meet these difficulties.

The size of this institution is inadequate to care for the needs. It should be extended to number at least 500 beds, in order to meet the demands which will undoubtedly be made upon the place. As soon as public health officers throughout the country learn that they may place their lepers in a satisfactory institution of this kind, search for these unfortunates will be stimulated, and they will be gradually collected and segregated to the interest of themselves and every community. At the present time applications for admission to this home exceed by a good deal the number of beds which can be supplied with present appropriations. It is believed that Congress will view this matter in a sympathetic light and undoubtedly will extend the facilities of this institution sufficiently to care for all of the demands.

#### NEW UNITED ISRAEL ZION HOSPITAL IN BROOKLYN OPENS

United Israel Zion Hospital, occupying the block between Forty-eight and Forty-ninth Streets at Tenth Avenue, Brooklyn, was formally opened on September 17. The hospital dispensary opened for the reception of patients the previous week.

This institution, said to be the most modern hospital in Brooklyn, will serve the residents of Borough Park, Bath Beach, Bay Ridge, Bensonhurst, Coney Island and Flatbush.

Among those who attended the formal opening of the hospital were Mayor John F. Hylan, Welfare Commissioner Bird S. Coler, Borough President Edward Riegelmann, U. S. Senator William M. Calder, Supreme Court Justices Edward Lazansky, Mitchel May and Harry E. Lewis, Judge Alexander Geismar, the chief, medical staff and officers of the synagogues throughout the sections the hospital will serve. The hospital can accommodate 175 patients. There are fifty-three private rooms and six public wards.

It was erected and equipped at a cost of \$1,000,000. It possesses modern equipment and all the rooms face the sunlight. The general plan of the hospital is "H" shaped, ground at the northwest being left vacant for further construction as demands require. Each floor has its sun porch, facing south, where patient and bed may easily be wheeled.

The front pavilion contains the private service and the rear the public service. On each floor the pavilions are connected by corridors from which other wards and rooms open. A reception ward is provided, where patients will first be placed under observation for contagious and infectious diseases before being admitted to the proper ward.

On each floor, adjoining the wards, are isolation rooms where patients in distress or, who for other reasons would be disturbing to occupants of the same ward, may be transferred and placed under direct supervision of the nurse in charge. A labor room and delivery room, each of which is completely isolated against the transmission of noise, are located on the top floor of the building. Directly opposite the maternity ward is the nursery, which is sufficiently close to enable mothers to see the infants through glass sash. The ward, however, is far enough so that the infants cannot possibly disturb the rest of the mothers. The children's ward is particularly attractive with its large bay windows, facing south and with playrooms decorated with pictures and rhymes.

While the hospital is non-sectarian, all Jewish dietary laws have been conformed with in the laying out of the kitchens. Among the devices of modern equipment which have been installed are steam cooking apparatus, electric meat choppers, electric vegetable paring machines, electric and steam dishwashing machines, electric ice cream freezer and bread cutters.

Much care has been exercised in laying plans for the laundry so as to insure the utmost efficiency. To this end, modern devices of electrical and steam apparatus have been installed.

#### RED CROSS ROLL CALL BEGINS ARMISTICE DAY

The annual Roll Call of the American Red Cross, in which its membership is renewed from year to year, will take place in the period between Armistice Day, November 11, and Thanksgiving Day. This is the only appeal that the national organization makes during the year and is for the purpose of maintaining its membership at such a point as will enable it to perform those duties which are placed upon it by Congress.

For purposes of the 1922 Roll Call three posters have been prepared. One of these, "At the Service of All Mankind," is by Lawrence Wilbur, and another by Franklin Booth, the latter being a sketch of the Capitol on which is superimposed the Red Cross. The third poster, "The Planters," is for use in the Junior Red Cross Roll Call and is by Anna Milo Upjohn, the well-known painter of child subjects.



## SOCIAL SERVICE IN THE STATE HOSPITAL

By HANNAH CURTIS, DIRECTOR OF SOCIAL WORK, STATE DEPARTMENT OF MENTAL DISEASES, BOSTON, MASS.

**P**OSSIBLY in no field is social service more necessary than in state hospital work. Patients confined in institutions of this type are frequently placed there without their knowledge or consent; their statements are often so colored or clouded by their mental illness that credence seldom is given to them; their social unfitness for community life is indicative of the need of special guidance; serious family situations often arise from the enforced commitment of heads of families. These and other factors clearly indicate the need of a group of specially trained people who may work in both hospital and community.

There are still various conceptions as to the real purpose and function of state hospital social service, although it is nearly ten years old in Massachusetts and is in process of establishment in other parts of the country. Several reasons might be offered in explanation of the lack of uniformity in development and interpretation, but a few may help to clarify or explain the rather indefinite statements which are occasionally made concerning this work.

### Duties Are Widely Varied

Until recently all medical social work has been more or less vaguely understood and a great variety of activities, in many cases unrelated, has characterized hospital social work in general. It is quite generally acknowledged that social service must adapt itself to the individual needs of an institution; this being true, the very peculiar and varied needs of a state hospital for mental patients account in a large measure for the diversity of duties of the social service which, at times, are quite unrelated to the general principles of social work. In developing work of this kind it is important to note that the laws regulating the care and treatment of mental patients are not uniformly established throughout the country and customs and traditions relative to such patients must, therefore, be considered largely from local viewpoints. These and other factors which have a direct bearing upon public care of mental patients have doubtless added to confused thinking and cloudy interpretation of state hospital social work and have made it relatively difficult to offer concrete statements of the work with especial reference to its functions and values.

It is quite true that the early activities of practically all state hospital social service departments are diversified and in many instances unrelated to

general principles of social work. It is equally true that wherever those activities have been carefully modified and directed into the proper channels, the real purpose and functions of this service have become clearly apparent and properly related to fundamental principles of hospital social work. As we are now emerging from the experimental stage of state hospital social service, it seems very important that special emphasis be laid upon the necessity of consciously establishing departments of social work in state institutions upon the recognized basis of all hospital social work, "assistance in the medical care and treatment of patients," otherwise its main purpose may ultimately fail of realization. In so far as this is done, the variety of activities will not necessarily cause confusion and misunderstanding because their relationship will be clearly defined.

In reality a close relationship exists between medical and social service when viewed from the standpoint of treatment. The patient is the unit of interest for both physician and social worker. The physician, into whose care the patient is entrusted, gathers his data on the ward, in the laboratory or library.

These data are analyzed, interpreted and related to a general plan of treatment, the ultimate purpose of which is restoration of health. The wise physician includes in his plan the related social factors, consequently the social worker is requested to go into the community and gather facts relative to environmental conditions and social relationships, and to study those factors which are associated with the mental health of patients. In addition to these factors an attempt is made to determine the degree of the patient's social adaptability and to create conditions suitable for community life. These data are analyzed, interpreted and related to a general plan of treatment by the social worker who also aids in carrying out the plan. This merging of medical and social service is fundamentally important if the institution is to deal effectively with persons whose mental condition and community relations are often seriously complicated.

### Misconduct and Mental Illness Interrelated

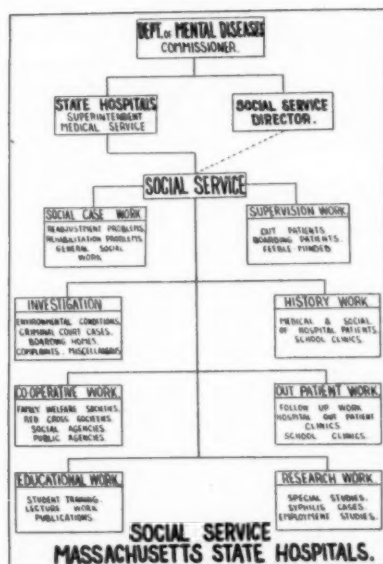
The most effective social work with patients is noted in those instances in which the physician from the first builds into his treatment plan those elements which relate to the social well being of the patient as an individual. This is particularly important in those cases in which the outstanding



symptoms of mental disorder are closely associated with some form of social misconduct. The interrelation of mental disorder and social misbehavior makes it doubly imperative that studies be made relative to personality, home and industrial conditions and social relationships with a view to relating the same to the general plan of treatment. The institution which adopts such a policy usually possesses a social consciousness and recognizes its obligations and responsibilities not alone to patients and their relatives, but to community organizations and to the general public.

### The Massachusetts Program

In Massachusetts, a program for the development of social service in state institutions is primarily founded upon the central underlying principles of hospital social work with the expectation that the activities of the various departments shall be consciously directed and related to the medical social care and treatment of mental patients. The accompanying diagram indicates the organization scheme and main divisions of work.



It will be noted in observing this chart that the work divides itself into two main divisions—

(a) Intensive and slight service work *directly* related to the treatment of patients.

(b) Community work, more or less *indirectly* associated with treatment work which is essentially of an educational nature.

Although the bulk of state hospital social work is at present done in the community, a need for inside hospital social service is becoming more apparent. It is thought that the development of this phase of the work will result in more intelligent and continuous service in selected cases which indicate a need of constructive social case work.

### Human Element Not Fully Developed

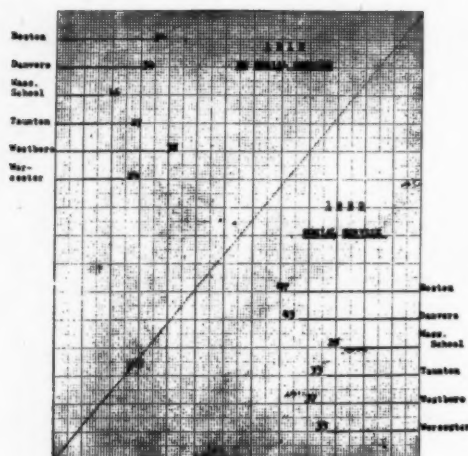
To the community the state hospital social service represents the human element of institution treatment and rightly so. It is very doubtful if this aspect of institution care has been duly and proportionately considered as compared with other departmental activities. The immediate relatives of patients and the public at large are apparently not so deeply concerned with the material development of state institutions or with scientific research as they are with measures which are directly related to the welfare of patients confined therein. Possibly one of the reasons why public financial support has not been more readily and cheerfully given is because the human element in hospital methods has not been sufficiently developed and emphasized to enlist lively public interest and cooperation. If then, the bond between hospital social service and the community is based largely upon the human interest element it fills a very great need; it does not, however, necessarily imply that such work is purely humanitarian for it relates itself directly to scientific and economic factors.

This interpretation of state hospital social work by the community has undoubtedly been largely instrumental in establishing the splendid degree of cooperation which is being realized in many communities, not alone in the contribution of information so necessary in the care of patients in the hospital, but in the assistance which is given in the community supervision and care of outpatients.

### Patients Cured as Social Service Develops

Coincident with the advent of social service in state institutions, an increased number of outgoing patients have been noted. Modern methods of psychiatric treatment have doubtless been instrumental in this development, which is noted in various parts of the country since the way opened up whereby hospital extension work might be accomplished through social service. In order to determine more accurately the expansion of this phase of social work, a study was recently made of six Massachusetts institutions relative to outgoing patients. Two periods were chosen, 1912, the year prior to the advent of social service in state hospitals and 1920, when each of the six institutions had at least one social worker. The functions and population of these hospitals were practically the same for both periods. Increases in the number of outgoing patients were noted in all institutions with one exception, which may be accounted for on the ground that this hospital was in 1920 undergoing a process of reorganization.

The accompanying chart illustrates the foregoing statement:



The progress of any department of hospital organization probably depends, to a great extent, upon its actual value to all concerned, especially to patients. Considering social work from the standpoint of values, one discovers it to be of a threefold nature: (a) therapeutic; (b) economic; (c) educational.

From the therapeutic viewpoint we note: (1) patients who are able to appreciate the fact of out-patient social service and its various aspects must receive considerable relief from worry or anxiety over home and financial affairs which are often seriously affected by hospital commitment; (2) the modification or removal of conditions which have been contributing factors to mental breakdown may, in many instances, prevent or retard a recurrence of mental illness; (3) in the community out-patients are connected, when necessary, with medical resources; and (4) moral support is not infrequently given to patients by social workers.

In measuring the economic value of social work to the institution, it is hardly necessary to state that the value of a human being cannot be financially determined. However, when any group of persons is under consideration for care at public expense, the financial cost of such care always becomes a very important factor and must therefore be considered in connection with this division of hospital activity.

In considering the great economic waste which naturally results upon the confinement of persons within an institution, it is important to devise means, when expedient, whereby such persons may in due course of time be restored to a degree of economic efficiency. The economic value of a department which attempts to do work of this kind, even in a small way, is obviously worthy of consideration. In many cases patients are in-

dustrially restored and readjusted, or partially so. Every patient released from the hospital and thus assisted becomes a contributor to the commonwealth of society and is a direct saving to the state in hospital maintenance. The possibility of releasing greater numbers of patients under adequate supervision will depend largely upon the development of well equipped social service departments in our institutions.

The educational value of psychiatric social work may be noted (a) in the instruction and guidance which are given to patients and relatives in regard to social factors pertaining to mental hygiene and social adaptiveness; (b) in the enlightenment to community agencies and industries relative to the peculiar needs of mental patients; (c) in the contribution of social data to hospital physicians which may be used in treatment or research work. Better knowledge of mental diseases will depend largely upon social investigation and observation in the community which are functions of the social worker.

### Some Results of the Work Enumerated

The actual results of almost any kind of work connected with individuals must be largely conjectural. There are, however, certain obvious results of social service concerning which there can be but little difference of opinion. Through the investigation and case work of this department, actual facts in regard to the cases of patients are secured which frequently have a direct bearing upon diagnostic and treatment work; especially is this valuable in questions of discharge or parole visits.

The confidence of the community in the hospital care of out-patients is being established to the extent that patients are now much more readily received and more humanely treated, although much remains to be done in this field. It is becoming much easier to place patients in industry under supervision.

Definite information relative to hospital methods and treatment of mental disorders, when given at first hand to citizens outside an institution, results in modifying the stigma which for centuries has been attached to mental patients and to institutions erected for their care.

Definite policies which are established with community agencies through social service increase the possibilities for improved and more extensive community service.

The future development and progress of state hospital social work may be said to depend mainly upon three important factors:

(1) An enlightened public opinion through actual service and educational methods.



(2) The sincere and active interest and cooperation of those who are actually engaged in the care, treatment and prevention of mental diseases and allied ailments.

(3) The securing of a body of well trained, properly qualified social workers whose chief interest lies not in the development of social work as a profession but in the actual welfare of human beings, who because of mental or character ailments are socially incapacitated unless proper treatment can be administered.

### GUIDE TO HOSPITAL SOCIAL SERVICE

Mercy Hospital at Pittsburgh has published an informative little four-page pamphlet entitled "Use the Social Service Department" which serves to introduce the public to the purposes of such work. It is divided into three parts: whom the social service department serves, when to use it and how to use it.

Because of the conciseness of its presentation the contents of the pamphlet are reprinted here as a suggestion to other institutions in developing their social service departments:

#### Social Service Department Aims to Be of Service To Patients

By securing adequate medical care for those who need it.

By helping to restore them to normal life—normal physically, mentally, and morally—as quickly as possible.

By directing them to other agencies when there is some problem other than a medical problem involved.

By remedying the social maladjustments that cause and prolong illness, such as poverty, bad housing, poor sanitation, sufficient food or improper diet, immoral surroundings.

#### To Physicians and Nurses

By assisting in diagnosis through giving information regarding patient's home conditions and family history when such information cannot be obtained by a hospital interview.

By assisting in treatment through removing from home conditions any possible hindrances to recovery.

By visiting the patient after discharge so that an early recurrence of illness will be prevented, and arranging for convalescent care when necessary.

By seeing that patient follows out the advice given.

#### To The Management

By keeping the management in touch with the work and development of public and private health organizations.

By interpreting for it the problems of society which are of vital concern to the hospital in its work.

By showing the need and value of the extension of dispensary facilities.

#### To The Community

By carrying into the homes of the community the educational influences of the hospital.

By helping to check the spread of disease by seeking out those in need of treatment.

By reducing poverty through the reduction of illness.

By bringing to light, social and economic causes underlying physical disabilities.

### When to Use the Social Service Department In General

In any instance where there appears to be a deviation from the normal standard of living; for example: where there seems to be lack of proper food, clothing or shelter, insufficient income, immoral living conditions.

If the patient says he cannot accept the medical treatment advised because of children or other dependents, the social service department will endeavor to arrange for their care during treatment.

#### In The Hospital

If hospital care can be of no further service to patient, other accommodations may be secured so as to give room to a curable patient.

If patient is ready for discharge but needs a few weeks' rest in the country before going home, convalescent care may be arranged.

If patient has no place, or no desirable place, to go upon discharge.

If patient needs an interpreter.

If patient needs legal advice.

If patient is a deserted or unmarried mother and has no relatives that are likely to care for her upon discharge, or if her legal rights have not been looked after.

If patient needs treatment after discharge.

If patient is handicapped and needs employment fitted to his handicapped condition.

If patient should be in a home for the aged or in a hospital for the insane.

If patient desires or needs reading material.

#### In The Dispensary

In any instance where the examining physician recognizes the possible existence of a hindrance to recovery at home.

If patient cannot or will not take the treatment or advice or appliances recommended.

If patient has a communicable disease.

If patient has a communicable disease and other members of the family have not been examined.

If patient has a communicable disease and is to report regularly for treatment.

If patient is an expectant mother.

### How to Use the Social Service Department

The aims of the department can be accomplished only through the closest cooperation and watchfulness on the part of everyone who comes in contact with the sick. Everyone associated with the hospital is essentially a part of the social service department.

The service of the department is not confined to non-paying patients.

The department believes in securing payment for medical service in every instance where payment is possible, and in asking for free medical service for only truly needy cases.

It is not within the scope of the work of the department to make direct financial investigations; however, if the financial circumstances of a patient are known to the department, such information will be given when requested.

We are all travelers in what John Bunyan calls the wilderness of this world \* \* \* and the best that we find in our travels is an honest friend. He is a fortunate voyager who finds many. We travel indeed, to find them. They are the end of the reward of life. They keep us worthy of ourselves; and when we are alone, we are only nearer to the absent.—R. L. Stevenson.



## The MODERN HOSPITAL

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## SUPERINTENDENTS MAY PLAY PART IN ARCHITECTURAL CONTEST

MANY superintendents of small hospitals are working in buildings that are ill adapted to the institution's purpose. The laboratory is poorly located, the diet kitchens are too small, there are too few closets, the store room is difficult to get at. How often have we heard these superintendents express the wish that they might have an opportunity to cooperate with an architect in the planning of an efficient small hospital!

Such an opportunity is now offered them through THE MODERN HOSPITAL architectural competition for the plans of small hospitals. Indeed at the recent convention of the American Hospital Association several superintendents of small institutions expressed the intention of sketching their ideas of a thirty or forty bed hospital and getting their local architects to cooperate with them in drawing plans to conform to the provisions of the magazine's program.

To know that a goodly number of superintendents of small hospitals were cooperating with architects in the preparation of plans for submission in this contest would be gratifying. Superintendents undoubtedly have a valuable contribution to make in the planning of the small hospital. They know its requirements as do few architects who have not specialized in the planning of institutions of this character. In the interests of the better planning of small hospitals superintendents would do well to act on this suggestion.

## PROLAPSIS SENSI HUMORI

THERE is a disease, not necessarily fatal but extremely prevalent, which exerts an extremely untoward influence on official efficiency. It may be congenital or acquired; it may be incurable but if recognized and subjected to careful treatment, it may be greatly ameliorated. Frequently it is easily cured. Sometimes the therapeutic measures must cover a considerable time, but no case should be classed as hopeless unless it is desired to consign the patient to chronic mediocrity. It is the one disease in which the patient may act as his own physician with impunity, in fact self treatment is absolutely essential to relief.

The disease exists in two forms. The first and more serious, known as ahumori, (don't look in the dictionary—the word is new) is a congenital absence of the sense of humor. This may be hereditary but may be cured if treated early. The second, or prolapsus sensi humori, is largely acquired. This is a temporary falling or lowering



of the sense of humor—at first an acute affection but prone to continue chronically. Either of these diseased states may be recognized by an observant layman; unfortunately the victim seldom makes the diagnosis and may even refuse to accept it at the hands of some well-meaning and therefore irritating friend.

In order that the discussion of the pathological condition may be approached logically, it is necessary to consider first of all the normal state in which the sense of humor has reached a proper degree of development. The sense of humor may be defined as that mental quality of detachment of the ego which permits one to stand aside and view impersonally the acts of one's self or other persons, and, having viewed them, to arrive at an impartial appraisal thereof. It is a thing apart from the sense of the obviously funny, yet the qualities of wit and fun enter into it. Fun carries with it the idea of playful action or speech. Wit is more purely intellectual and implies swift perception of the incongruous. Humor implies broader human sympathies, a more kindly sense of the incongruous often blended with pathos. The derivation of the word humor from the old Latin, meaning to be moist, conveys the idea that humor is the opposite of the dry and pessimistic. Thus it partakes of the sense of the ludicrous, yet in a kindly way, since it recognizes the partnership of the ridiculous in almost every human act. It is the antithesis of selfishness and its twin brothers, self-conceit and sham. It is a blessing to its possessor, a heartener when trouble comes and a chastener in the hour of success.

The concentration of official life seems to furnish the ideal for the fall of the sense of humor. One's job looks so big that everybody else's job seems to dwindle by comparison. One's work becomes a sacred thing to be protected against the inroads of all persons. Every little precedent of that job becomes a part of holy ritual and the very suggestions of change take on the aspect of the sacrilegious. The result is a drying up of the humor of human understanding and with the evaporation of this blessed fluid, there occurs a loss in mental volume, a narrowing of the perspective and a complete solidification of the fount of charity.

The acts of those about us take on a meaning which is absolutely foreign to their real intention. Opportunity knocks in vain at the door of a mind whose ears are deaf to all outside stimuli. Chronic mediocrity and the dull treadmill round of life continue until the kindly hand of time translates the unfortunate victim to the place where every one has a sense of humor. If heaven were otherwise, it would not be heaven.

The cure for this condition is found in not taking it to heart. We should realize that the work is going to go on a long time after we are dead; that if we do our work well now, the end results will take care of themselves in the future. Above all, let us not take ourselves or other people too seriously.

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### TO BUILD INSTITUTIONS BY BONDS

THE state of New Jersey not long ago attempted to raise money by a bond issue with which to rehabilitate and enlarge its charitable, penal and correctional institutions and to provide five additional ones.

Sixteen million dollars was asked. An extensive and thorough campaign was made by the state department of institutions. The governor of the state endorsed the issue. Friends of the helpless and unfortunate made appeals to the voters for support. Evidence was submitted showing graphically the need for the money. It was thoroughly explained that the existing institutions are far too small to accommodate those actually present within their walls, that there are many outside waiting for vacancies and that the state is not performing its full duty by the many who should be cared for in institutions.

The issue was safeguarded so that no additions could be made to taxes on its account. This was accomplished by providing that the annual interest and sinking fund obligations should have the first call upon the state's funds. The general assembly, according to the plan, should each year make an appropriation of funds sufficient to cover interest and sinking fund for these bonds. These two items should be included in the state budget, which is limited. Whatever was left unappropriated would be available for the other expenses of the state. This scheme admirably prevented any increase in taxes through a bond issue for this purpose.

Voters, however, did not take to the idea and the issue was defeated.

Those who supported it are confident that the campaign opened the eyes of the public to the inadequacy of the institutions in that state and to the failure of the state to make provision for types which are now recognized as proper subjects for institutionalization.

The public charitable, penal and correctional institutions all through the country have sunken into physical deterioration, are so far behind the times in economical and modern equipment and are so far short of capacity to meet the demands upon them, that the prevailing system of small annual doles by the general assembly

scarcely keeps them above the surface. Heroic means, such as the proposed New Jersey bond is sue, are required to rescue these institutions and to establish them where they can perform for the state the service that it needs for its own protection and welfare.

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### NOMINATIONS FROM THE FLOOR

ONE of the outstanding features of the recent conference of the American Hospital Association at Atlantic City was the advantage taken of the recent constitutional amendment making it allowable to nominate officers from the floor and to elect by ballot.

There has existed in the association for many years a feeling that the selection of officers should not be left altogether in the hands of the nominating committee, and this meeting offered the first opportunity for the convention as a whole to express its wishes in the selection of officers for the ensuing year; this it did.

Arising from the satisfaction that came out of this procedure there is little doubt but that a high impartiality and devotion to the general interest of the association will result.

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### APPROVED HOSPITAL LIST GROWS

THE list of approved hospitals published last year by the American College of Surgeons contains the names of 564 or 74 per cent of the 761 general hospitals of 100 or more beds then existing in the United States and Canada. This represented an addition to the list of 176 hospitals during the year, but left 197 hospitals of 100 beds or more unapproved. We expressed the hope at that time that the 1922 list of the College would contain 90 per cent or more of the hospitals of 100 beds or more. As a matter of fact the 1922 list, which was made public at the Clinical Congress held at Boston on October 23-27, 1922, shows that 83 per cent of the 812 general hospitals of 100 beds in existence during 1922 are on the list.

Although the list as originally announced at the 1921 Clinical Congress contained 564 general hospitals, the number grew to 579 or 76 per cent of the total. Up to the time of the Clinical Congress the gain for this year, therefore, in terms of hospitals of one hundred beds or more is 98, in terms of percentage, seven. To this year's list, however, have been added 355 hospitals having a capacity of between fifty and 100 beds. This number represents 41 per cent of the 811 general hospitals of this size listed by the College. Taking the aggregate list of 1623 hospitals having 50 or more beds, 1012 or 62 per cent are meeting the minimum standards of the College. In view of the

greater difficulties the smaller hospitals have in establishing the minimum standard they make an excellent showing in this first published list of approved hospitals of 50 to 100 beds and, as the College's reports indicate, are to be especially commended.

The publication of each successive list of the College gives increasing evidence of the desire of hospitals to give their patients the best service that modern medicine and modern hospital organization afford.

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### OVERCROWDING IN STATE HOSPITALS

ILLINOIS reports a net increase of 900 patients in its state hospitals during the year 1921. This is the greatest annual net increase on record in that state.

The American Legion and other organizations of soldiers of the recent World War complain to President Harding and to the Veterans' Bureau of the crowding of soldier patients in state hospitals.

Crowding has been a chronic condition for a long time in these institutions. The charge cannot be denied. Patients have been packed into state hospitals in every state until a situation has developed which is positively indecent and inhumane. No state that respects the truth has denied that its hospitals for nervous and mental cases have been crowded beyond reason. Doubtless other states have experienced increases in their hospital population comparable with that in Illinois in 1921. Institutions already overcrowded for years are now confronted with an unprecedented influx of patients, and the humiliating situation is to be aggravated since little provision has been made in the way of new wards to accommodate this gain in population.

New Jersey recently tried to put over a bond issue of \$14,000,000 with which to rehabilitate and enlarge its state charitable and penal institutions, but the plan was defeated at the polls. Legislatures, confronted with desperate demands for money from numerous sources, overlook the insane and feeble-minded because there are few to speak for them. Their plight does not make the sound that hard roads and a dozen other subjects create when the whole populace unites to ask for them because they contribute to general comfort, convenience and prosperity.

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Bishop Berkeley long ago suggested that, apart from the percipient mind, matter had no existence. Modern science stretches out a hand to him across the centuries, and agrees that matter may be nothing more than a condition of motion affecting our senses.—Robert W. MacKenna.



## SMALL HOSPITAL ARCHITECTURAL CONTEST AWAKENS INTERNATIONAL INTEREST

**D**ESIGNED to arouse the small community of the United States and Canada to its need of hospital facilities and to provide it with plans of a structure efficient in arrangement and inspiring in architecture, THE MODERN HOSPITAL'S \$1,000 competition already has exceeded the imagined limits of its originators and the boundaries of a continent.

Within little more than the minimum time for the postal delivery between Chicago and London carrying the announcement of this magazine's plan of conducting an architectural contest on small hospital plans, there were received from the British capital three inquiries for details of the competition, a request for programs from the Royal Institute of British Architects and the registration of Architect Win Kidd of Chelsea, London. Other requests have followed in rapid succession.

Enthusiasm over the competition displayed by a New Zealand architect in a personal call at the Chicago office of THE MODERN HOSPITAL led to the dispatch, at his suggestion, of contest programs to the New Zealand Institute of Architects at Wellington. Publicity given the project in several French and German architectural journals has developed some interest in these countries.

Through such a succession of inquiries, THE MODERN HOSPITAL awoke to a realization of the international character of its competition. Since the contest was made open to all architects, contributions from foreign architects will be accepted.

To accommodate foreign competitors, the registration date for the contest, originally set for November 15 has been advanced one month. American architects also will be allowed to register their intention of entry up until December 15. This change of program has necessitated a change in the final date for submitting designs which under the revised plan becomes February 1. Com-

munications in regard to the competition or the program will be received by the architectural adviser, Mr. Richard E. Schmidt of Chicago, up until January 1. Any information sought must be by anonymous letter, and a copy of such a letter and the answer to it will be sent simultaneously to each competitor.

In the United States and Canada interest in the competition has been instantaneous and widespread. Requests for programs have poured in from most of the Canadian provinces. The various sections of the country are surprisingly well represented among registrants. Only architects of the northwest have lingered over their registration, but from inquiries and requests for programs it is anticipated that several from that section will be entered before the deadline for registration is reached.

New York, New Jersey, District of Columbia, Tennessee, South Carolina, Georgia, Kentucky, Arizona, California, Minnesota, Indiana and Illinois, all have one or several architects competing.

Architectural Adviser Richard E. Schmidt of the firm, Richard E. Schmidt, Garden & Martin of Chicago, has put a liberal interpretation on the

### UNTIL DECEMBER 15 TO REGISTER

*Architects who desire to enter the \$1,000 prize competition being conducted by THE MODERN HOSPITAL for plans of a community hospital of 30 to 40 beds will be given until December 15 to register. The final date of registration has been set forward an entire month with a consequent advance of the date for submitting designs to February 1, 1923.*

*Registrations, inquiries, and calls for the contest program from England, several European countries, and even New Zealand, have necessitated an extension of the registration limit. Foreign interest in the competition was entirely unanticipated by THE MODERN HOSPITAL, owing to the vastly different conditions governing hospital construction abroad, but the contest is open to all architects and any such designs will not be excluded.*

*Requests for complete programs of the competition have been reaching the Chicago office of the magazine at the rate of thirty a day, from architects not included among the original 1,800 to whom programs were mailed early in October. In the first fortnight following the announcement of the competition at the American Hospital Association conference at Atlantic City, twenty persons registered their intention of submitting designs.*

word "architect" as employed in the general program of the contest and will accept the registrations of draftsmen in the offices of architectural firms. Post-graduate and even advanced students in colleges of architecture also will be allowed to submit designs and colleges will of course be eligible and it is hoped that several of them will try for the prizes.

Inspired by the example of several superintendents, who at the American Hospital Association convention in Atlantic City expressed their intention of cooperating with their local architects in submitting designs, other hospital administrators have set about plotting their dream of a modern small hospital or a remodelled present structure and will turn their suggestions over to their local architect for elaboration.

An interesting phase of the competition thus far is that heads of several well known firms in hospital architecture are competing with draftsmen from their own offices.

A jury of award, its personnel to include two architects of recognized standing, two seasoned hospital superintendents, and one registered nurse who has had experience in small hospital administration, will be announced in the December issue.

Throughout the period of the contest will be published a series of articles on small hospital construction. In this issue are described the Egeland Hospital, a private institution at Sturgeon Bay, Wis., and the Grinnell Community Hospital, an actively functioning health center at Grinnell, Iowa.

## MORE THAN 1,000 HOSPITALS OF FIFTY OR MORE BEDS MEET MINIMUM STANDARD OF A. C. S.\*

A HIGH ideal of hospital service, a vision of community responsibility, a method by which this responsibility can be met efficiently day by day—this is Hospital Standardization. The following pages contain a report for 1922 of the progress of this movement—that of giving to the public the best service known to the science of medicine. It stands as a tribute to the idealism and the service of the combined medical and hospital professions.

Soon after its organization, the American College of Surgeons felt the urgent need of improving hospital records, as applicants for admission to the College were required to submit as a part of their examination one hundred case records of major operations. These records were so incomplete and fragmentary in many instances that the College became thoroughly convinced of the necessity for a widespread campaign to improve them. This was the initial germ causing the hospital standardization movement; as it developed, other factors in hospital betterment presented themselves, such as the need for more adequate laboratory service and more efficient staff organization.

### The Hospital Staff

The first consideration in the minimum standard, as evolved by the American College of Surgeons in 1919, is the hospital staff. It is unfortunately true that organization in hospital effort has not advanced to a degree comparable with its development in other technical lines. Surely there is no excuse for the human repair shop—the hospital—to fall behind in organization, always all important in promoting the highest efficiency. Responsibility for the various activities of the hospital must be centered in certain committees or individuals. The program for the staff meetings, the case records, the laboratory service, the nursing care, and the intern service, are but a few of the important activities, the responsibility for which should be centralized.

The goal of the organized staff, and indeed the aim of

the standardization program, is the analysis of the hospital's results. As expressed by Mr. John G. Bowman, "The staff meeting is the pivot upon which the success or failure of hospital standardization turns." It is the medium, through which this entire campaign finds expression. Without it, a hospital's efforts to a large degree fail.

The staff conference, perhaps more than any other factor, has improved the tone of hospital service during the past few years. It is the feeling of the College that these meetings should be devoted largely to a discussion of the so-called casualties, including deaths, infections, complications, and unimproved cases.

### Laboratories

One of the great advances in modern medicine has been in the direction of laboratory aid in diagnosis. Indeed, this constitutes one of the greatest distinctions between the practice of medicine today and that of our forefathers. Hospitals owe their patients the benefits of this advance in medical science. The laboratory in no sense, however, should be considered as a shortcut to diagnosis, supplanting the careful taking of a history and a painstaking physical examination. Combined with the latter, however, it furnishes an invaluable means of assistance, often making clear an otherwise obscure diagnosis.

The necessity, then, for making careful arrangements for adequate laboratory service, needs no argument. As a minimum, hospitals should have facilities for the examination of urine, blood, exudates, bacteriological slides, and for the growth of cultures. It may be impractical, however, for some hospitals to have equipment for the more technical examinations, such as serological and histological tests. Arrangements must be made with a reliable laboratory for accurate and prompt service for these more detailed examinations.

Even in hospitals with complete laboratory facilities, one frequently finds laboratory service markedly deficient, due to the insufficient quantity of tests performed, especially for private patients. This is due largely to two

\*Extracts from the report for 1922 of the American College of Surgeons on Hospital Standardization, together with a complete list of 1,102 general hospitals of fifty or more beds in the United States and Canada which meet the minimum standard of the College.



causes: first, the system of charging an individual fee for each test performed; and second, to the apathy of many staff members toward the laboratory. It cannot be too strongly emphasized that almost without exception, hospitals which charge individual fees for their laboratory tests, perform a relatively small number of tests per patient. Under such conditions, naturally, the hospital cannot assume a definite routine of laboratory service, as an immediate objection to the cost would be raised. The only solution apparent at the present time is the adoption of a flat-rate fee. This allows the hospital, and rightly, to assume the responsibility of having each patient receive adequate laboratory aid. The uniform success of this plan has been proved in so many instances, that it can be accepted as an established fact.

The x-ray department in the hospital should have a qualified roentgenologist in charge, if only in a part-time, supervisory capacity. Patients, in general, do not receive uniformly competent service if interpretations are relegated to individual physicians.

The College makes no specific recommendations concerning the number of routine laboratory examinations to be employed by hospitals. A routine urinalysis, of course, is performed in the majority of hospitals. Many perform a routine hæmoglobin determination and leucocyte count also—a practice to be strongly recommended. Some hospitals have a routine Wassermann test in certain wards or services. Fortunately, the practice of having a routine examination of every tissue removed in the operating room is becoming quite prevalent. This is a factor of paramount importance. Every specimen from the operating room should be sent to the laboratory automatically; this should be as rigid a part of the operating room technique as the sterilization of instruments. Every specimen should be examined by the pathologist, who submits at least a gross report of his examination and has a histological examination made whenever possible. Data of tremendous scientific value are becoming available due to the practice of sectioning practically all specimens from the operating room. Furthermore, this practice gives the hospital an insight into its operating room service that can be obtained in no other way.

### Case Records

The absolute and fundamental importance of case records is a commonly acknowledged fact and needs no argument here. A careful study of the history of a patient's illness and a painstaking physical examination are procedures of such great importance that their value must be preserved. Failure to record these data constitutes a tremendous economic loss and waste, to say nothing of the future bearing on the welfare and lives of the patients. How then, can the possession of a complete record system be facilitated? Its accomplishment requires the mutual cooperation of the hospital and its staff members.

The duties of the hospital in this connection consist, first of all, in supplying adequate personnel to secure the records. In the absence of interns, record clerks are essential. Even the small hospital is entitled to a full-time historian, although it is quite common for these historians to devote part of their time to other activities of the hospital. An efficient record committee is another necessary adjunct to the historian's work.

Many hospitals fail to provide adequate space for the record department. For this purpose a room large enough to contain the records of many years should be set aside, adjacent to the hospital office. All plans for

new hospitals should bear this important feature in mind. This department should contain standard filing cabinets and card indices for names and diseases; for each record must be immediately accessible.

Personal study in over 1,600 hospitals during the past four years has shown a progressive improvement in the records. Certain prevalent shortcomings, however, are worthy of special emphasis. Extreme brevity is a common fault, coupled with a tendency to dismiss important regions of the body from consideration by too promiscuous use of the words "normal," or "negative." A tendency to a stereotyped form of history and physical examination record is encountered frequently. Such charts have little individuality or clinical value and result from two causes: failure to record the data until shortly before or after the patient's discharge; and from lack of supervision of the records by the hospital staff.

The importance of having the working diagnosis recorded early is insufficiently realized. This, in itself, will correct many existing difficulties in connection with other phases of the records. Operation records are almost universally weak in describing the exploratory findings and operative technique. The solution for this seems to be the dictation of these data during or immediately following each operation.

### Method and Results of the Surveys

The hospital surveys of the College are *personal* surveys. Experience has shown that a study of hospital conditions through the correspondence and questionnaires leads to many inaccuracies. The College surveys are conducted through a trained corps of hospital visitors, all of whom are graduates in medicine. The number of visitors employed in any year has never exceeded ten. Since the uniformity of a survey varies in inverse proportion with the number of men employed, by using relatively few visitors, all similarly trained, the College obtains strictly uniform reports. As an additional safeguard, each visitor covers a large number of states and provinces in order that he may obtain a general, rather than a local, viewpoint of hospital conditions. This uniformity in the reports is an absolute essential to a just rating of hospitals. Upon such detailed personal surveys, the College is dependent for an accurate estimate of each hospital's status relative to the minimum standard.

The purpose of the visitors is to explain the minimum standard, to interpret its application to each hospital, and to offer constructive criticism and helpful suggestions to remedy any existing shortcomings. This campaign is one of suggestion only; there is no element of coercion entailed. It succeeds through the sanction and approval of the hospitals themselves.

Other organizations interested in hospital betterment have played a prominent rôle in advancing hospital standardization. The program of the College has been enhanced greatly by the endorsement of such organizations as the American Hospital Association, the American Conference on Hospital Service, the Canadian Medical Association, the Catholic Hospital Association, the Conference Board of Hospitals and Homes of the Methodist Church, the Medical and Surgical Section of the American Railway Association, the Methodist Hospital Association, the Protestant Hospital Association, and numerous state, provincial, and local organizations.

Interns and nurses are using the approved list of the College as a guide in the selection of institutions in which to pursue their training. The public is making increasing use of it as a means of determining which institu-

tions offer safe and competent hospital care. Benevolent foundations employ it in deciding upon hospitals which are worthy of financial aid. The American Railway Association has recommended that all railroad employees, wherever possible, be treated in hospitals meeting the minimum standard. The United States Government, in its selection of hospitals for the treatment of its disabled veterans, utilizes the information furnished through the surveys and approved lists of the College.

Four annual surveys of the general hospitals in the United States and Canada have been made. Of the institutions having one hundred or more beds, 89 were found to meet the standard in 1918; in 1919, 198 fulfilled the requirements; in 1920, 407 or 57 per cent met the standard; in 1921 the number of approved hospitals grew to 579 or 76 per cent; and this year 677 or 83 per cent of the 812 hundred bed general hospitals are on the approved list.

Of the 811 general hospitals having a capacity of between fifty and one hundred beds, 335 or 41 per cent are approved, an excellent showing in view of the fact that previous lists published by the College have not included these smaller institutions.

Grouping together the 1,623 general hospitals having fifty or more beds, there are 1,012 or 62 per cent meeting the requirements of the standard.

### The Fifty Bed Hospitals

Although the College has been surveying the smaller hospitals since 1920, it was deemed advisable to withhold their publication on the approved list until sufficient time had elapsed to give them an opportunity to familiarize themselves thoroughly with the standardization program.

The smaller hospitals are under greater difficulties than the larger institutions. Many are forced to be practically self-supporting; the physicians are more prone to develop personal rivalries which retard staff organization; it is difficult for them to obtain interns; and sufficient laboratory service is often a serious problem. In spite of these difficulties, however, the small hospitals have welcomed the minimum standard with the same spirit manifested by the large institutions. Indeed, it is in these small hospitals that the greatest change in hospital service has been manifested. It requires patience to establish a complete case record system; to organize a harmoniously functioning staff; and to arrange for adequate laboratory service. These small institutions are to be especially commended, therefore, on the excellent showing which they have made.

### Hospital Standardization

In the United States and Canada there are 811 general hospitals having between fifty and one hundred beds. Of these, 335 or 41 per cent are on the approved list. This exceeds the percentage of hundred bed hospitals which met with approval at the time of the first survey.

The surveys of the College have demonstrated that the hospitals of this continent are receptive to any means of improving their service to the public. As the sphere of hospitals has widened, so have their responsibilities increased. Sensing these ever deepening responsibilities and obligations, hospitals looked forward to a means of satisfying their broadened conception and ideals of community service. The minimum standard and the standardization program of the College furnished a concrete method by which these aspirations could be reached. The future will see the further elaboration by hospitals of the principles of the minimum standard, and a fuller realization of the spirit embodied therein.

## LIST OF APPROVED HOSPITALS<sup>1</sup>

### Capacity of 50 Beds and Over

The following list contains the names of those general hospitals of fifty or more beds, in the United States and Canada, which meet the minimum standard. In this list a certain number of the institutions are designated with an asterisk. This group includes those hospitals which, when visited, had adopted the fundamental principles of the minimum standard, but which at that time had not developed all of them to a degree meriting the fullest approval. The hospitals listed without an asterisk have received the benefits of a longer experience in the workings of the program and consequently a broader conception of its application.

#### UNITED STATES

##### ALABAMA

100 or more beds

- \*Birmingham Baptist Hospital, Birmingham
- Employees Hospital, T. C. I. & R. R. Co., Birmingham.
- Hillman Hospital, Birmingham
- Mobile City Hospital, Mobile
- \*Norwood Hospital, Birmingham
- \*Providence Infirmary, Mobile
- \*St. Vincent's Hospital, Birmingham
- South Highlands Infirmary, Birmingham

50 to 100 beds

- \*Alabama Baptist Hospital, Selma
- \*John A. Andrew Memorial Hospital, Tuskegee
- Vaughan Memorial Hospital, Selma

##### ARIZONA

100 or more beds

- \*St. Joseph's Hospital, Phoenix

##### ARKANSAS

100 or more beds

- Logan H. Roots Memorial Hospital, Little Rock
- St. Louis Southwestern Hospital, Texarkana
- St. Vincent's Hospital, Little Rock
- \*Sparks Memorial Hospital, Fort Smith

50 to 100 beds

- Baptist State Hospital, Little Rock
- \*Leo N. Levi Memorial Hospital, Hot Springs
- Michael Meagher Memorial Hospital, Texarkana
- St. Bernard's Hospital, Jonesboro
- St. Luke's Hospital and Annex, Little Rock

##### CALIFORNIA

100 or more beds

- Alameda County Hospital, San Leandro
- Children's Hospital, Los Angeles
- Children's Hospital, San Francisco
- \*French Hospital, San Francisco
- \*Fresno County Hospital, Fresno
- \*Golden State Hospital, Los Angeles
- Hospital for the Good Samaritan, Los Angeles
- Lane Hospital, San Francisco
- \*Loma Linda Sanitarium and Hospital, Loma Linda
- Los Angeles County Hospital, Los Angeles
- Mary's Help Hospital, San Francisco
- Mt. Zion Hospital, San Francisco
- \*O'Connor Sanitarium, San Jose
- Pasadena Hospital, Pasadena
- Providence Hospital, Oakland
- \*Sacramento Hospital, Sacramento
- St. Francis Hospital, San Francisco
- St. Joseph's Hospital, San Diego
- St. Joseph's Hospital, San Francisco
- St. Mary's Hospital, San Francisco
- St. Vincent's Hospital, Los Angeles
- San Diego County Hospital, San Diego
- San Francisco Hospital, San Francisco
- \*San Joaquin General Hospital, French Camp
- Santa Barbara Cottage Hospital, Santa Barbara
- Santa Clara County Hospital, San Jose
- Santa Fe Coast Lines Hospital, Los Angeles
- Southern Pacific Hospital, San Francisco
- University of California Hospital, San Francisco
- White Memorial Hospital, Los Angeles

50 to 100 beds

- \*Mercy Hospital, Bakersfield
- \*Murphy Memorial Hospital, Whittier
- \*Paradise Valley Sanitarium, National City
- \*Ramona Hospital, San Bernardino
- \*St. Francis Hospital, Santa Barbara

##### COLORADO

100 or more beds

- Children's Hospital, Denver
- Glockner Sanatorium, Colorado Springs
- Mercy Hospital, Denver
- Minnequa Hospital, Pueblo
- St. Anthony's Hospital, Denver
- St. Francis Hospital, Colorado Springs
- \*St. Joseph's Hospital, Denver
- \*St. Luke's Hospital, Denver
- St. Mary's Hospital, Pueblo

<sup>1</sup>This list is complete only to October 6, 1922.



## 50 to 100 beds

- \*Denver and Rio Grande Western Railroad Hospital, Salida
- \*Red Cross Hospital, Salida

## CONNECTICUT

## 100 or more beds

- Bridgeport Hospital, Bridgeport
- Grace Hospital, New Haven
- Greenwich General Hospital, Greenwich
- Hartford Hospital, Hartford
- \*Hospital of St. Raphael, New Haven
- Lawrence and Memorial Associated Hospitals, New London
- New Haven Hospital, New Haven
- St. Francis Hospital, Hartford
- St. Mary's Hospital, Waterbury
- St. Vincent's Hospital, Bridgeport
- \*Stamford Hospital, Stamford
- Waterbury Hospital, Waterbury

## 50 to 100 beds

- New Britain General Hospital, New Britain

## DELAWARE

## 100 or more beds

- Delaware Hospital, Wilmington

## 50 to 100 beds

- \*Homeopathic Hospital, Wilmington

## DISTRICT OF COLUMBIA

## 100 or more beds

- Central Dispensary and Emergency Hospital, Washington
- Children's Hospital, Washington
- Columbia Hospital for Women, Washington
- Freedman's Hospital, Washington
- Garfield Memorial Hospital, Washington
- George Washington University Hospital, Washington
- Georgetown University Hospital, Washington
- Providence Hospital, Washington
- \*Washington Sanitarium and Hospital, Washington.

## FLORIDA

## 100 or more beds

- \*Duval County Hospital, Jacksonville
- \*St. Luke's Hospital, Jacksonville

## 50 to 100 beds

- Gordon Keller Memorial Hospital, Tampa
- \*Miami City Hospital, Miami

## GEORGIA

## 100 or more beds

- \*Davis-Fischer Sanatorium, Atlanta
- Georgia Baptist Hospital, Atlanta
- Grady Memorial Hospital, Atlanta
- Harbin Hospital, Rome
- Piedmont Sanatorium, Atlanta
- \*St. Joseph's Infirmary, Atlanta
- University Hospital, Augusta

## 50 to 100 beds

- \*Athens General Hospital, Athens
- \*Downey Hospital, Gainesville
- \*Park View Sanitarium, Savannah
- Scottish Rite Hospital, Decatur

## IDAHO

## 100 or more beds

- St. Alphonsus Hospital, Boise

## 50 to 100 beds

- Pocatello General Hospital, Pocatello
- \*Providence Hospital, Wallace
- St. Anthony's Hospital, Pocatello
- \*St. Luke's Hospital, Boise

## ILLINOIS

## 100 or more beds

- Alexian Brothers Hospital, Chicago
- Augustana Hospital, Chicago
- Chicago Lying-In Hospital, Chicago
- Children's Memorial Hospital, Chicago
- Columbus Hospital, Chicago
- Cook County Hospital, Chicago
- Evanston Hospital, Evanston
- \*Frances E. Willard Hospital, Chicago
- Grant Hospital, Chicago
- Hahnemann Hospital, Chicago
- \*Hinsdale Sanitarium, Hinsdale
- \*Hospital of St. Anthony de Padua, Chicago
- Illinois Central Hospital, Chicago
- \*Illinois Charitable Eye and Ear Infirmary, Chicago
- \*Lake View Hospital, Danville
- Lutheran Deaconess Hospital, Chicago
- Mersey Hospital, Chicago
- Michael Reese Hospital, Chicago
- Misericordia Hospital, Chicago
- Mt. Sinai Hospital, Chicago
- Presbyterian Hospital, Chicago
- Rockford Hospital, Rockford
- St. Anne's Hospital, Chicago
- St. Bernard's Hospital, Chicago
- \*St. Elizabeth's Hospital, Chicago
- \*St. Elizabeth's Hospital, Danville
- St. Francis Hospital, Blue Island
- St. Francis Hospital, Evanston
- St. Francis Hospital, Peoria
- St. Joseph's Hospital, Chicago
- \*St. Joseph's Hospital, Joliet
- St. Luke's Hospital, Chicago
- \*St. Mary's Hospital, East St. Louis
- St. Mary's Hospital, LaSalle
- \*St. Mary's Infirmary, Cairo
- St. Mary of Nazareth Hospital, Chicago
- South Shore Hospital, Chicago
- Swedish Covenant Hospital, Chicago
- University Hospital, Chicago
- \*Washington Park Hospital, Chicago
- Wesley Memorial Hospital, Chicago

## 50 to 100 beds

- \*Columbus Extension Hospital, Chicago
- \*Garfield Park Hospital, Chicago
- Huber Memorial Hospital, Pana
- Illinois Masonic Hospital, Chicago
- \*Lake View Hospital, Chicago
- \*Lutheran Hospital, Moline
- North Chicago Hospital, Chicago
- Olney Sanitarium, Olney
- Our Saviour's Hospital, Jacksonville
- Passavant Memorial Hospital, Jacksonville
- \*Post-Graduate Hospital, Chicago
- \*Provident Hospital, Chicago
- St. Andrew's Hospital, Murphysboro
- \*St. Francis Hospital, Freeport
- \*South Side Hospital, Chicago
- Washington Boulevard Hospital, Chicago

## INDIANA

## 100 or more beds

- Fort Wayne Lutheran Hospital, Fort Wayne
- Gary Hospital, Gary
- Indianapolis City Hospital, Indianapolis
- Methodist Episcopal Hospital, Indianapolis
- Robert W. Long Hospital, Indianapolis
- St. Anthony's Hospital, Terre Haute
- St. Elizabeth's Hospital, LaFayette
- St. Joseph's Hospital, Fort Wayne
- St. Margaret's Hospital, Hammond
- St. Mary's Hospital, Evansville
- St. Mary's Mercy Hospital, Gary
- St. Vincent's Hospital, Indianapolis

## 50 to 100 beds

- Epworth Hospital, South Bend
- \*Holy Family Hospital, LaPorte
- LaFayette Home and Hospital, LaFayette
- Muncie Home Hospital, Muncie
- \*Protestant Deaconess Home and Hospital, Evansville
- \*Reid Memorial Hospital, Richmond
- St. Joseph's Hospital, South Bend
- \*Union Hospital, Terre Haute
- Walker Hospital, Evansville

## IOWA

## 100 or more beds

- Finley Hospital, Dubuque
- Iowa Lutheran Hospital, Des Moines
- Iowa Methodist Hospital, Des Moines
- Jennie Edmundson Hospital, Council Bluffs
- Mersey Hospital, Cedar Rapids
- Mersey Hospital, Council Bluffs
- Mersey Hospital, Davenport
- \*Mersey Hospital, Des Moines
- St. Francis Hospital, Waterloo
- St. Joseph's Mercy Hospital, Dubuque
- St. Joseph's Mercy Hospital, Sioux City
- St. Vincent's Hospital, Sioux City
- University Hospital, Iowa City

## 50 to 100 beds

- \*Iowa Congregational Hospital, Des Moines
- \*Iowa State College Hospital, Ames
- \*Lutheran Hospital, Sioux City
- \*Ottumwa Hospital, Ottumwa
- Park Hospital, Mason City
- St. Joseph's Mercy Hospital, Clinton
- St. Joseph's Mercy Hospital, Fort Dodge
- St. Joseph's Mercy Hospital, Mason City
- \*St. Joseph's Mercy Hospital, Waverly
- \*Samaritan Hospital, Sioux City

## KANSAS

## 100 or more beds

- Bethany Methodist Hospital, Kansas City
- St. Francis Hospital, Wichita
- St. Margaret's Hospital, Kansas City
- \*Wichita Hospital, Wichita

## 50 to 100 beds

- Axtell Hospital, Newton
- Bell Memorial Hospital, Kansas City
- Halstead Hospital, Hasteed
- Hutchinson Methodist Hospital, Hutchinson
- \*Mersey Hospital, Fort Scott
- \*Mt. Carmel Hospital, Pittsburg
- Providence Hospital, Kansas City
- \*St. Elizabeth's Hospital, Hutchinson
- St. Francis Hospital, Topeka
- St. John's Hospital, Salina
- \*St. Joseph's Hospital, Concordia

## KENTUCKY

## 100 or more beds

- Good Samaritan Hospital, Lexington
- Louisville City Hospital, Louisville
- Norton Memorial Hospital, Louisville
- St. Anthony's Hospital, Louisville
- \*St. Elizabeth's Hospital, Covington
- SS. Elizabeth and Mary Hospital, Louisville
- St. Joseph's Hospital, Lexington
- St. Joseph's Infirmary, Louisville

## 50 to 100 beds

- \*Booth Memorial Hospital, Covington
- \*Children's Free Hospital, Louisville
- \*Deaconess Hospital, Louisville
- Illinois Central Hospital, Paducah
- \*Jewish Hospital, Louisville

## LOUISIANA

## 100 or more beds

- Charity Hospital, New Orleans
- Hotel Dieu, New Orleans
- \*Presbyterian Hospital, New Orleans
- St. Francis Sanitarium, Monroe
- T. E. Schumpert Memorial Hospital, Shreveport
- Touro Infirmary, New Orleans

## 50 to 100 beds

- \*Illinois Central Railroad Hospital, New Orleans
- \*North Louisiana Sanitarium, Shreveport

## MAINE

## 100 or more beds

- Eastern Maine General Hospital, Bangor
- \*Maine General Hospital, Portland
- \*St. Mary's General Hospital, Lewiston

## 50 to 100 beds

- \*Children's Hospital, Portland

## MARYLAND

## 100 or more beds

- \*Alleghany Hospital, Cumberland
- Bay View City Hospital, Baltimore
- Church Home and Infirmary, Baltimore
- Franklin Square Hospital, Baltimore
- Hebrew Hospital and Asylum, Baltimore
- Hospital for Women of Maryland, Baltimore
- Johns Hopkins Hospital, Baltimore
- Maryland General Hospital, Baltimore
- Mercy Hospital, Baltimore
- Morrow Hospital, Baltimore
- St. Agnes Hospital, Baltimore
- St. Joseph's Hospital, Baltimore
- Union Memorial Hospital, Baltimore
- University Hospital, Baltimore

## 50 to 100 beds

- Children's Hospital School, Baltimore
- Emergency Hospital, Easton
- Frederick City Hospital, Frederick
- South Baltimore General Hospital, Baltimore

## MASSACHUSETTS

## 100 or more beds

- Beverly Hospital, Beverly
- Boston City Hospital, Boston
- Brookton Hospital, Brookton
- \*Burbank Hospital, Fitchburg
- Cambridge City Hospital, Cambridge
- Cambridge Hospital, Cambridge
- Carney Hospital, Boston
- Children's Hospital, Boston
- City Hospital, Fall River
- \*Cooley-Dickinson Hospital, Northampton
- Free Hospital for Women, Boston
- Holyoke City Hospital, Holyoke
- House of Mercy Hospital, Pittsfield
- Lawrence General Hospital, Lawrence
- Long Island Hospital, Boston
- Lowell Corporation Hospital, Lowell
- Lowell General Hospital, Lowell
- Lynn Hospital, Lynn
- \*Malden Hospital, Malden
- Massachusetts Charitable Eye and Ear Infirmary, Boston
- Massachusetts General Hospital, Boston
- Massachusetts Homeopathic Hospital, Boston
- Memorial Hospital, Worcester
- Mercy Hospital, Springfield
- New England Hospital for Women and Children, Boston
- Newton Hospital, Newton Lower Falls
- \*Noble Hospital, Westfield
- Peter Bent Brigham Hospital, Boston
- Providence Hospital, Holyoke
- St. Elizabeth's Hospital, Boston
- St. John's Hospital, Lowell
- \*St. Luke's Hospital, New Bedford
- St. Vincent's Hospital, Worcester
- Salem Hospital, Salem
- Springfield Hospital, Springfield
- Union Hospital, Fall River
- \*Waltham Hospital, Waltham
- \*Weason Memorial Hospital, Springfield
- Worcester City Hospital, Worcester

## 50 to 100 beds

- Beth Israel Hospital, Boston
- Boston Lying-in Hospital, Boston
- Clinton Hospital, Clinton
- Farren Memorial Hospital, Montague City
- \*Faulkner Hospital, Boston
- \*Hart Private Hospital, Brookline
- House of the Good Samaritan, Boston
- Infants' Hospital, Boston
- North Adams Hospital, North Adams
- \*Quincy City Hospital, Quincy
- Truesdale Hospital, Fall River

## MICHIGAN

## 100 or more beds

- Battle Creek Sanitarium, Battle Creek
- Blodgett Memorial Hospital, Grand Rapids
- Butterworth Hospital, Grand Rapids
- Children's Free Hospital, Detroit
- Detroit Receiving Hospital, Detroit
- \*Edward W. Sparrow Hospital, Lansing
- \*Evangelical Deaconess Hospital, Detroit
- Grace Hospital, Detroit
- Hackley Hospital, Muskegon
- Harper Hospital, Detroit
- Henry Ford Hospital, Detroit
- Highland Park General Hospital, Highland Park
- House of Providence, Detroit
- \*Hurley Hospital, Flint
- Mercy Hospital, Bay City
- \*New Borgess Hospital, Kalamazoo
- \*Old Borgess Hospital, Kalamazoo
- St. Joseph's Hospital, Ann Arbor
- St. Mary's Hospital, Detroit
- St. Mary's Hospital, Grand Rapids
- University Hospital, Ann Arbor
- W. A. Foote Memorial Hospital, Jackson
- Woman's Hospital and Infants' Home, Detroit

## 50 to 100 beds

- \*Bronson Methodist Hospital, Kalamazoo
- \*Detroit Eye, Ear, Nose and Throat Hospital, Detroit
- \*Ishpeming Hospital, Ishpeming
- Memorial Hospital, Owosso
- Mercy Hospital, Jackson
- \*Nichols Memorial Hospital, Battle Creek
- Saginaw General Hospital, Saginaw
- St. Mary's Hospital, Saginaw
- Samaritan Hospital, Detroit

## MINNESOTA

## 100 or more beds

- \*Abbott Hospital, Minneapolis
- Bethesda Hospital, St. Paul
- \*Charles T. Miller Hospital, St. Paul
- City and County Hospital, St. Paul
- Colonial Hospital, Rochester
- Deaconess Hospital, Minneapolis
- \*Eitel Hospital, Minneapolis
- Fairview Hospital, Minneapolis
- Minneapolis General Hospital, Minneapolis
- Minnesota State Hospital for Indigent Children, St. Paul
- Mounds Park Sanitarium, St. Paul
- Northern Pacific Beneficial Association Hospital, St. Paul
- Northwestern Hospital, Minneapolis
- St. Barnabas Hospital, Minneapolis
- St. Joseph's Hospital, St. Paul
- \*St. Luke's Hospital, Duluth
- \*St. Luke's Hospital, St. Paul
- St. Mary's Hospital, Duluth
- St. Mary's Hospital, Minneapolis
- St. Mary's Hospital, Rochester
- St. Paul Hospital, St. Paul
- Swedish Hospital, Minneapolis
- University of Minnesota Hospital, Minneapolis
- Worrell Hospital, Rochester

## 50 to 100 beds

- Hill Crest Surgical Hospital, Minneapolis
- \*Immanuel Hospital, Mankato
- \*St. Gabriel's Hospital, Little Falls
- St. John's Hospital, St. Paul
- \*St. Joseph's Hospital, Mankato
- St. Raphael's Hospital, St. Cloud

## MISSISSIPPI

## 100 or more beds

- East Mississippi Charity Hospital, Meridian

## MISSOURI

## 100 or more beds

- Alexian Brothers Hospital, St. Louis
- Barnes Hospital, St. Louis
- Children's Hospital, Kansas City
- Christian Church Hospital, Kansas City
- \*Evangelical Deaconess Home and Hospital, St. Louis
- Frisco Employees Hospital, St. Louis
- \*Grace Hospital, Kansas City
- Jewish Hospital, St. Louis
- Kansas City General Hospital, Kansas City
- Lutheran Hospital, St. Louis
- Missouri Baptist Sanitarium, St. Louis
- Missouri Pacific Railroad Hospital, St. Louis
- Research Hospital, Kansas City
- St. Anthony's Hospital, St. Louis
- St. John's Hospital, St. Louis
- St. Joseph's Hospital, Kansas City
- St. Louis Children's Hospital, St. Louis
- St. Louis City Hospital, St. Louis
- St. Louis Mullanphy Hospital, St. Louis
- St. Luke's Hospital, St. Louis
- St. Mary's Hospital, Kansas City
- St. Mary's Infirmary, St. Louis

## 50 to 100 beds

- Bethesda Hospital, St. Louis
- \*Frisco Employees Hospital, Springfield
- \*Parker Memorial Hospital, Columbia
- \*St. Francis Hospital, Cape Girardeau
- St. Francis Hospital, Maryville
- St. John's Hospital, Joplin
- St. Luke's Hospital, Kansas City
- St. Mary's Hospital, Jefferson City
- Trinity Lutheran Hospital, Kansas City
- University Hospital, Kansas City

## MONTANA

## 100 or more beds

- Columbus Hospital, Great Falls
- Montana Deaconess Hospital, Great Falls
- Murray Hospital, Butte
- St. James Hospital, Butte
- \*St. Patrick's Hospital, Missoula

## 50 to 100 beds

- \*Bozeman Deaconess Hospital, Bozeman
- \*Northern Pacific Beneficial Association Hospital, Missoula
- \*St. Ann's Hospital, Anaconda
- \*St. Joseph's Hospital, Lewistown
- St. Vincent's Hospital, Billings

## NEBRASKA

## 100 or more beds

- Nebraska Methodist Episcopal Hospital, Omaha
- St. Elizabeth's Hospital, Lincoln
- St. Francis Hospital, Grand Island
- St. Joseph's Hospital, Omaha
- St. Mary's Hospital, Columbus
- University of Nebraska Hospital, Omaha

## 50 to 100 beds

- \*Immanuel Deaconess Hospital, Omaha
- Presbyterian Hospital, Omaha
- \*Swedish Mission Hospital, Omaha

## NEVADA

## 50 to 100 beds

- \*Elko General Hospital, Elko



## NEW HAMPSHIRE

100 or more beds

St. Joseph's Hospital, Nashua

50 to 100 beds

- \*Elliott Hospital, Manchester
- \*Hospital of Notre Dame, Manchester
- Mary Hitchcock Memorial Hospital, Hanover
- Nashua Memorial Hospital, Nashua

## NEW JERSEY

100 or more beds

- Alexian Brothers Hospital, Elizabeth
- Atlantic City Hospital, Atlantic City
- Bayonne Hospital and Dispensary, Bayonne
- Christ Hospital, Jersey City
- Cooper Hospital, Camden
- Elizabeth General Hospital, Elizabeth
- Englewood Hospital, Englewood
- Hackensack Hospital, Hackensack
- Jersey City Hospital, Jersey City
- Mercer Hospital, Trenton
- Monmouth Memorial Hospital, Long Branch
- Morristown Memorial Hospital, Morristown
- Mountainside Hospital, Montclair
- Muhlenberg Hospital, Plainfield
- Newark Beth Israel Hospital, Newark
- Newark City Hospital, Newark
- Newark Memorial Hospital, Newark
- \*Newark Presbyterian Hospital, Newark
- Orange Memorial Hospital, Orange
- Passaic General Hospital, Passaic
- Paterson General Hospital, Paterson
- St. Elizabeth's Hospital, Elizabeth
- St. Francis Hospital, Jersey City
- St. Francis Hospital, Trenton
- \*St. Joseph's Hospital, Paterson
- \*St. Mary's Hospital, Hoboken
- \*St. Michael's Hospital, Newark
- \*St. Peter's General Hospital, New Brunswick

50 to 100 beds

- Ann May Memorial Hospital, Spring Lake
- \*Homeopathic Hospital, Newark
- \*Hospital and Home for Crippled Children, Newark
- \*Hospital for Women and Children, Newark
- \*Middlesex General Hospital, New Brunswick
- Nathan and Miriam Barnert Memorial Hospital, Paterson
- \*St. James Hospital, Newark

## NEW YORK

100 or more beds

- Albany Hospital, Albany
- \*Arnot-Ogden Memorial Hospital, Elmira
- Bellevue Hospital, New York
- Beth Israel Hospital, New York
- Beth Moses Hospital, Brooklyn
- \*Binghamton City Hospital, Binghamton
- Broad Street Hospital, New York
- Brooklyn Hospital, Brooklyn
- Brownsville and East New York Hospital, Brooklyn
- Buffalo City Hospital, Buffalo
- Buffalo General Hospital, Buffalo
- Buffalo Hospital of Sisters of Charity, Buffalo
- \*Bushwick Hospital, Brooklyn
- Carson C. Peck Memorial Hospital, Brooklyn
- Children's Hospital, Buffalo
- Clifton Springs Sanitarium, Clifton Springs
- Community Hospital, New York
- Coney Island Hospital, Brooklyn
- Cumberland Street Hospital, Brooklyn
- Ellis Hospital, Schenectady
- Flower Hospital, New York
- Flushing Hospital and Dispensary, Flushing
- Fordham Hospital, New York
- French Benevolent Society Hospital, New York
- Gouverneur Hospital, New York
- Greenpoint Hospital, Brooklyn
- Hahnemann Hospital, New York
- Harlem Hospital, New York
- Highland Hospital, Rochester
- Holy Family Hospital, Brooklyn
- Homeopathic Hospital, Albany
- Hospital of the Good Shepherd, Syracuse
- Jewish Hospital, Brooklyn
- Kings County Hospital, Brooklyn
- Lebanon Hospital, New York
- Lenox Hill Hospital, New York
- Lincoln Hospital, New York
- Long Island College Hospital, Brooklyn
- Manhattan Eye, Ear and Throat Hospital, New York
- Memorial Hospital, New York
- Methodist Episcopal Hospital, Brooklyn
- Metropolitan Hospital, New York
- Misericordia Hospital, New York
- Montiflore Hospital, New York
- Mt. St. Mary's Hospital, Niagara Falls
- Mt. Sinai Hospital, New York
- Mt. Vernon Hospital, Mt. Vernon
- New York City Hospital, Blackwell's Island, New York
- \*New York Eye and Ear Infirmary, New York
- New York Foundling Home, New York
- New York Hospital, New York
- New York Hospital for Ruptured and Crippled, New York
- New York Infirmary for Women and Children, New York
- New York Nursery and Children's Hospital, New York
- New York Orthopedic Hospital, New York
- New York Post-Graduate Hospital, New York
- New York Skin and Cancer Hospital, New York
- \*New York State Hospital, West Haverstraw
- Niagara Falls Memorial Hospital, Niagara Falls
- Norwegian Lutheran Deaconess Hospital, Brooklyn
- Oneida County Hospital, Rome
- Presbyterian Hospital, New York
- Rochester General Hospital, Rochester
- Rochester Homeopathic Hospital, Rochester

- Roosevelt Hospital, New York
- St. Catherine's Hospital, Brooklyn
- St. Francis Hospital, New York
- St. John's Brooklyn Hospital, Brooklyn
- St. John's Hospital, Long Island
- St. John's Riverside Hospital, Yonkers
- \*St. Joseph's Hospital, Syracuse
- St. Luke's Hospital, New York
- St. Mark's Hospital, New York
- St. Mary's Free Hospital for Children, New York
- St. Mary's Hospital, Brooklyn
- St. Mary's Hospital, Rochester
- St. Peter's Hospital, Albany
- St. Peter's Hospital, Brooklyn
- St. Vincent's Hospital, New York
- Samaritan Hospital, Troy
- Sloane Hospital for Women, New York
- Staten Island Hospital, Tompkinsville
- Syracuse Memorial Hospital, Syracuse
- Troy Hospital, Troy
- Women's Hospital, New York
- Wyckoff Heights Hospital, Brooklyn
- Yonkers Homeopathic Hospital and Maternity, Yonkers

50 to 100 beds

- Anthony N. Brady Maternity Hospital, Albany
- \*Auburn City Hospital, Auburn
- Babies Hospital, New York
- Broad Street Hospital, Oneida
- Columbus Extension Hospital, New York
- Columbus Hospital, New York
- Emergency Hospital of Sisters of Charity, Buffalo
- Faxton Hospital, Utica
- \*Frederick Ferris Thompson Hospital, Canandaigua
- \*General Hospital, Syracuse
- Geneva City Hospital, Geneva
- Glens Falls Hospital, Glens Falls
- \*Harbor Hospital, Brooklyn
- Jamaica Hospital, Jamaica
- Jewish Maternity Hospital, New York
- Knickerbocker Hospital, New York
- Lawrence Hospital, Bronxville
- Mary Immaculate Hospital, Jamaica
- Mary McClellan Hospital, Cambridge
- \*Nassau Hospital, Mineola, Long Island
- \*Nathan Littauer Hospital, Gloversville
- New Rochelle Hospital, New Rochelle
- Ossining Hospital, Ossining
- Park Avenue Clinical Hospital, Rochester
- Peoples Hospital, New York
- \*Prospect Heights Hospital, Brooklyn
- Reconstruction Hospital, New York
- St. Bartholomew's Hospital, New York
- St. Christopher's Hospital for Babies, Brooklyn
- St. Vincent's Hospital, West New Brighton
- Saratoga Hospital, Saratoga Springs
- \*Swedish Hospital, Brooklyn
- Williamsburg Hospital, Brooklyn

## NORTH CAROLINA

100 or more beds

- \*James Walker Memorial Hospital, Wilmington
- \*Presbyterian Hospital, Charlotte
- \*St. Leo's Hospital, Greensboro
- Watts Hospital, West Durham

50 to 100 beds

- \*Asheville Mission Hospital, Asheville
- Atlantic Coast Lines Railroad Hospital, Rocky Mount
- Burrus-McCain Hospital, Highpoint
- City Memorial Hospital, Winston-Salem
- Highsmith Hospital, Fayetteville
- \*Long's Sanitarium, Statesville
- Park View Hospital, Rocky Mount
- Rutherford Hospital, Rutherfordton
- \*Salisbury Hospital, Salisbury

## NORTH DAKOTA

100 or more beds

- Bismarck Evangelical Deaconess Hospital, Bismarck
- \*Grand Forks Deaconess Hospital, Grand Forks
- St. Alexis Hospital, Bismarck
- St. John's Hospital, Fargo
- St. Luke's Hospital, Fargo

50 to 100 beds

- \*St. Joseph's Hospital, Minot
- St. Michael's Hospital, Grand Forks

## OHIO

100 or more beds

- \*Aultman Hospital, Canton
- Bethesda Hospital, Cincinnati
- Christ Hospital, Cincinnati
- Cincinnati General Hospital, Cincinnati
- City Hospital, Akron
- Cleveland City Hospital, Cleveland
- Good Samaritan Hospital, Cincinnati
- Good Samaritan Hospital, Zanesville
- Grant Hospital, Columbus
- Hawkes Hospital of Mt. Carmel, Columbus
- Huron Road Hospital, Cleveland
- Jewish Hospital, Cincinnati
- Lakeside Hospital, Cleveland
- Lucas County Hospital, Toledo
- Mercy Hospital, Hamilton
- Mercy Hospital, Toledo
- Miami Valley Hospital, Dayton
- Mt. Sinai Hospital, Cleveland
- Peoples Hospital, Akron
- Protestant Hospital, Columbus
- St. Alexis Hospital, Cleveland
- St. Elizabeth's Hospital, Dayton
- St. Elizabeth's Hospital, Youngstown
- St. Francis Hospital, Columbus
- St. John's Hospital, Cleveland
- \*St. Joseph's Hospital, Lorain

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## THE LIABILITY OF THE HOSPITAL

By JOHN A. LAPP, DIRECTOR, DEPARTMENT OF SOCIAL ACTION, N. C. W. C., CHICAGO.

THE term *liability* has an ominous sound. It brings up visions of disaster, financial ruin and bankruptcy. Liability is so terrorizing that men seek protection against its disasters. Liability insurance is now common against most of the risks which people run in this respect. Employers' liability, automobile owners' liability and liability against damage to others in many ways have now made liability and liability insurance well known to all men.

In this discussion of the liability of the hospital we are discussing a subject which has not received the attention it deserves. Hospitals have been more or less immune from liability in the past. Hospital managers are therefore startled when from time to time a court decision fixes definite responsibility upon the hospital for damages which may have been caused to patients or others in the conduct of a hospital.

This was strikingly shown by a recent decision in Ohio which held a hospital responsible and liable for damages to a patient caused by the incompetence of a nurse in its employ. Hospitals particularly in Ohio became much alarmed at the prospect of liability which it opened. Efforts were made to get the supreme court of that state to grant a re-hearing and to reverse its decision. The supreme court, however, stood upon its decision and the same now stands as the final word of the courts of the state of Ohio.

Before going further to the discussion of this case, it would be well to classify hospitals in order that there may be no confusion about the type of hospital which we are discussing. From the standpoint of this discussion, hospitals are classified as: (1) public, including municipal, state and federal hospitals; (2) private, charitable or benevolent institutions, not for profit; and (3) private institutions conducted for profit. It is the second of these groups which is to be discussed in this paper, namely the private, charitable or benevolent hospitals, not for profit. In passing it may be said that public hospitals are in almost all states exempt from liability for damages under the decisions of the courts in this country. The only recourse which is a doubtful one, is to sue personally the superintendent or other officer.

In the case of private hospitals operated for profit, the courts have held such hospitals responsible in the same manner that they would hold any other corporation for profit responsible. Such hospitals being private institutions conducted for profit do not fall within the exemptions of either the public hospitals or the charitable or benevolent hospitals.

### Rulings of States Differ

We come then to the discussion of the liability of charitable or benevolent hospitals. Since these hospitals have been conducted as a public service without any possibility of profit to any one, they have been treated generally by the courts in a different and more lenient manner than private corporations conducted for profit would be treated. There is, however, a great diversity of conclusions concerning the liability of such hospitals. This variety extends all the way from almost complete exemption on the one hand, to a rather strict interpretation of liability on the other.

For instance, in the state of Massachusetts, in a case

decided in February, 1920 (*Roosen vs. Hospital*, 126 N. E. 392), the extreme view of exemption from liability was held. The court went so far as to state that "a public charitable hospital is not liable for the negligence of its managers in selecting incompetent subordinate agents, any more than it is for the negligence of subordinate agents selected with care." Thus the court decided no liability could attach to the act of any subordinate, whether that person were competent and selected with care or whether he were incompetent and selected in the full knowledge of his incompetency by the hospital. Decisions in some other states have upheld in whole or in part a similar finding, notably in Tennessee, South Carolina, Michigan and Illinois. The opposite view was expressed by the Ohio court in the recent decision in the case of *Taylor vs. Flower Deaconess Home and Hospital*, decided January 24, 1922.

In this case the court said: "We are convinced that sound reasons sustain the court to the effect that a public charity should not be held liable for the negligence of a servant in whose selection the hospital and managers have exercised due care. On the other hand such an institution is liable when it fails to exercise such care." This decision follows similar decisions in New York, Texas, Washington, Rhode Island, New Hampshire, Minnesota and Alabama. The New York case mentioned (*Goodman vs. Orphan Asylum* 165, N. Y. Supp. 149) declared: "The general principle protecting charitable institutions for actions for negligence does not include negligence that results in the choice of incompetent, unskilled or careless servants."

### Must Choose Subordinates Carefully

The decisions bring the point down to this,—that practically all states exempt hospitals from liability for damages caused by subordinates, if those subordinates are chosen with due care. A few states make such exemption, even for damages caused by subordinates selected without due care, but the weight of present opinion seems to be that the hospital will be held liable for damages unless it selects its servants with due care.

The protection which has been accorded to charitable hospitals has been, as previously stated, because of the public service which they render. A second reason of equal importance has been that since the funds of the hospital were given in trust for a charitable purpose they could not be diverted to pay judgments and they would be diverted even though the judgment might be paid from earned income from pay patients. Another reason for exemption has been that patients accepting the charity of the hospital were thereby held to waive any rights for damages which might be caused to them. Some courts have overruled these latter contentions and have held that such an exemption would work against the very interests which the donors had in making bequests to the hospital. In one case it was said that "While the public has an interest in the maintenance of a great public charity it also has an interest in seeing that every person and corporation which undertakes the performance of a duty performs it carefully."

A similar holding is the ruling case in England, where it was said that "By the admission of the patient to enjoy in the hospital the gratuitous benefit of its care



a hospital undertakes that the patient while there shall be treated only by experts, whether physicians, surgeons or nurses of whose professional competence the governors have taken reasonable care to assure themselves." This point of view is stated very forcefully in a North Carolina case (*Hoke vs. Glenn*, 167 N. C. 594) in which it was said: "The beneficiaries of charitable institutions are the poor, who have very little opportunity for selection, and it is the purpose of the founders to give to them skillful and humane treatment. If they are permitted to employ those who are incompetent and unskilled, funds bestowed for beneficence are diverted from their true purpose, and under the form of a charity they become a menace to those for whose benefit they are established." And in the Ohio case heretofore quoted it was declared that exemptions from liability "should be surrounded by such safeguards as will prevent the neglect of a duty which the hospital can and should perform. It cannot watch or control the countless acts and movements of its servants, but it can and should exercise care to see that only careful and competent servants minister to stricken patients who are within its walls. Moreover, while it may well be said that donors of funds for the praiseworthy objects of charitable hospitals do not contemplate the diversion of the fund for the payment of damages for the numerous acts of servants referred to, yet they necessarily realize and appreciate that they give their donations to those who have the management and control of the institution, and that every principle of justice requires that they use care in the development and maintenance of the property and in the selection of servants who have the oversight of patients. In our day there is a general tendency in all persons to resort to hospitals in cases which require surgical operations, or in cases of severe sickness, and for obvious reasons it is desirable that such an institution should neither be held out as devoted solely to the poor nor to the rich, and the degree of care required should in all cases be the same. The same rule should apply to a pay patient as to one who does not pay, and there is general agreement in this proposition."

Does the foregoing place upon the hospital an unduly heavy burden? Does the requirement that the hospital shall exercise due care in the selection of competent assistants create a dangerous liability? That does not appear to me to be the case. It places merely a reasonable requirement upon the hospital that it shall exercise due care in the selection of superintendents, surgeons, nurses and attendants. It does not ask of them that they do the impossible. A servant may be hired who is incompetent and unless the hospital managers in the exercise of due care knew or should have known that the person was incompetent, the hospital would not be liable. Thus, for example, a man might be hired as an ambulance driver who had epileptic seizures; the hospital necessarily would not be liable unless it knew that fact. It would be liable if it retained such a man in its employ as an ambulance driver after the facts became known.

A hospital might reasonably employ a physician by virtue of his license from the state to practice medicine without running a risk of liability, but if it should be discovered that such physician were incompetent or negligent, the hospital would be liable thereafter if it retained such man in its employ. How far this rule would apply to physicians who serve upon the staff of a hospital without being in the employ of the hospital, I am not prepared at this time to say. The hospital could not be held liable if a physician is negligent in treating his own patient who is brought into the hospital, which is acting in

the capacity of a hotel for the sick. It is not so clear, if the physician is on the staff of the hospital and treats a patient brought to the hospital, not as a private patient, but as a patient of the hospital.

It seems clear that the hospital would be responsible for acts of its superintendent or subordinate agent for grossly incompetent care if it were evident that the board of managers knew of the incompetence of such superintendent or subordinate agent. Of course unreasonable requirements cannot be enforced upon a hospital. Neither a hospital nor a physician is liable for a failure to give the best that the world affords. They are required to give the best, at least that the facilities and medical knowledge of the immediate community afford. A hospital in a small town remote from great medical centers would therefore not be held responsible for as many things, as would one located in a metropolitan center. If the hospital does the best it can with the lights and facilities it has, the rule of reason is satisfied. Hospitals and physicians should not be held responsible for acts or omissions when in the exercise of their judgment they did what they considered the best for the patient. Failure to perform an operation, though a post mortem should disclose that an operation would have saved the life of the patient, could not and of course should not create liability. Lack of supreme knowledge or mistakes in medical judgment cannot create liability.

In concluding this paper, which has necessarily been of general application, rather than of specific cases and types of liability, it seems fitting to suggest the relationship between certain proposed legislation and the liability of charitable hospitals.

It is perfectly clear that the liability of the hospital is increasing. It is perfectly clear also that such liability will continue to increase. If the hospital is to be held liable for negligence in the performance of its duties, especially because of its failure to select competent physicians, surgeons, nurses and attendants, then it would be wholly wrong and clearly unconstitutional for a legislature to attempt to compel a hospital to open its staff to all physicians entitled to practice medicine in any given community, as was proposed by bills introduced in various state legislatures during the past two years.

If the legislature can compel a hospital to put chiropractors on its staff, then the hospital could not be held liable justly for damages. The converse of this is also true, that if a hospital is held liable for negligent and incompetent agents, no other power but its own managers can have anything to say concerning the selection of those who are to perform the work of the hospital.

What should the hospital do about its legal liability? In the first place it should not get alarmed. The liability of a properly run hospital is very slight. Liability to damages may force upon trustees and managers greater attention to the trust which has been imposed upon them, but if their duties are properly performed there is slight cause for fear. On the other hand a hospital which is not properly run, a hospital which has a reputation for slovenly work and unsanitary conditions may well look to its liability.

Should the charitable hospital insure against liability? Yes, but not at exorbitant rates. Clearly the liability is slight in the average well managed hospital. Rates of insurance should therefore be extremely low.

May I suggest that insurance against liability may be provided best by a hospital mutual insurance company operating at cost by the hospitals themselves, thus following the example of numerous lines of business where such a plan is in successful operation?

## A FINANCIAL BASIS FOR EXTENDING THE WORK OF THE GRADUATE NURSE TO THE WHOLE PEOPLE

BY RICHARDS M. BRADLEY, TRUSTEE OF THE THOMAS THOMPSON TRUST, BOSTON, MASS.

AS A layman and a business man, I wish to speak on certain economic aspects of the nursing profession, in the belief that until certain economic defects in the present methods of nursing service are recognized and dealt with by nurses and their leaders, those features of the situation which everyone knows are unsatisfactory will continue, and will not be remedied by the many efforts, legislative and otherwise, that have absorbed much of the collective energy of the profession.

For more than twenty years, in connection with the use of money in dealing with the exigencies of sickness and maternity (having had occasion to expend for this purpose many hundred thousand dollars and having dealt with very many individual cases), I have come in contact with much nursing work in its direct application to the people. In this I have seen many able and noble women expending themselves to alleviate sickness and suffering and have seen many of them insufficiently compensated, not only in money but in results; therefore I feel I may not remain silent if anything can help which may be contributed from one able to look at the matter from a somewhat different angle, the economic and financial side as contrasted with the technical and professional side.

### Financial System is Primitive

It has been discovered lately that in all therapeutic work, the technical advance has gone ahead of progress in financial and organization lines, and steps are being taken in certain directions to remedy this. It would be a great misfortune if in this the graduate nurse was left out of consideration, and I therefore wish to indicate how she has been injured, and how she should come in, when dealing with plans for remedy.

Our general problem of care in sickness and maternity involves the application of modern methods to a population about 80 per cent of which belongs to the class called independent persons of moderate means.

According to recent estimates, the body of people with incomes of \$2,000, or less, received about 60 per cent of the gross annual income of the country, or some \$37,000,000,000 more or less. Since members of this class largely support the country, they must necessarily carry their own expenses, and success in giving them the advantage of modern therapeutic methods must therefore depend upon diverting an adequate part of their own income to this purpose.

Our trouble is that we are trying to operate with an old financial system that is too primitive for modern requirements.

Formerly, the ordinary family looked almost entirely to the family doctor and to the practical nurse in the emergencies of sickness and maternity, and although many lives were lost that would now be preserved, and much suffering and disability went without remedy, the financial problem was comparatively simple and was settled between the parties on personal lines. The case is different now. We have the hospital, the specialist, the surgeon, and the graduate nurse, all necessary if life and health are to be preserved, but all involving exceptional expenses.

These expenses are not of the class called regular living

expenses, such as food, clothing, rent, etc., but are of what might be called the catastrophe class, like fire or accident, striking here and there and involving exceptional families at irregular times in great expenses.

They are, however, expenses that can perfectly well be met through the benefit payment or insurance method, by distributing the exceptional loss over many families and over longer periods of payments, as is done with regard to other similar expenses and as is done for certain kinds of nursing service for the poorest part of the population by the Metropolitan Insurance Company.

In this connection, I find that there is an idea that such liabilities are covered for other classes by ordinary insurance underwritings, but so far as I can ascertain such policies are very limited in their number, seldom cover service to be rendered in sickness but merely loss of earnings, and seldom even then cover more than what happens to the income earner and not what happens to the earner's dependents.

Now, what is the effect of this condition of affairs upon the various modern agencies that have sprung up to handle sickness, especially the hospital, the specialist, the surgeon and the graduate nurse?

The hospital trustee and the nursing organization committee pass around the hat with intensified effort to meet their mounting deficit. Their endeavors in too many cases fall short and have the added disadvantage of undertaking to fulfill a vital public function that cannot be adequately discharged by the contribution method. In many cases they have lamentably failed in seasons of stress. They are conducting a great and important public industry without adequate financial foundation, and they are too often confronted with the alternative of not doing necessary work or inflicting great apparent hardship by charging heavily for it. This last may also be said of the hospitals that are supported largely through payments made by their patients.

The surgeon and the specialist have evolved the practice of charging Peter for the service of Paul. The difficulty of this method, apart from the liability to abuse, is that he can no longer extract from his richer patient sufficient to give adequate service to the poorer.

The result of all this has been inadequate service, hardship and general public dissatisfaction, and I have personally seen the hard-earned results of many years' saving swept away, and independent families reduced to suffering and dependence, all through perfectly legitimate charges for services rendered by hospitals and doctors and nurses.

### Nurse Deprived of Birthright

Now when does the graduate nurse find herself affected by this state of affairs? *I think it may be said that she is deprived of her birthright.* Her place is at the bedside of thousands and thousands of difficult and critical, often desperate cases, throughout the country where she is now unknown and often not even thought of. She cannot find full happiness and satisfaction in her work till this reproach is removed for which she is not to blame.

We have in the newly graduated nurse a young woman sent out from her place of education after giving three



or four of her best years to preparation ostensibly to do work that is now financially inaccessible in 80 per cent of the cases where it ought to be done. It is work at which she can probably not labor more than two-thirds of her time and retain her health and strength, and whether her hours be made longer or shorter, the years in which she can give her best powers are limited. In order to provide for herself and for her dependents, she must be adequately paid and that adequate pay must be a great expense at whatever amount it is finally placed.

She is not needed for all the cases of sickness; there are many that can be cared for by others (and should be so cared for) under her direction, and there is much work that has got to be done in the families of the sick that she cannot and should not do. But there is work that she should and must do in this great field all over the country now closed to her, a field that calls for all and more than all the graduates can do were that work properly organized and financed.

It is no satisfaction to her to see the morale of her profession undermined, by having the members in private nursing diverted to coddling the elderly rich or caring for the children of wealthy families in order that the mothers may shed their cares and travel, when she knows that in thousands of humble homes her services are needed by those who are suffering and dying for the lack of the skilled nursing that she alone can give. It is no satisfaction for her to find that in much organized nursing she is the paupers' rather than the people's nurse, and that the program laid out cannot possibly cover the people's needs.

#### Legislation Is Not Remedy

As to the remedy. It is no remedy to rely on legislation, for no more limiting of the numbers of women who do nursing will remedy the trouble. The way to overcome illegitimate competition of this kind is to do the work properly that has got to be done or to see that it is properly done. Moreover, there are none too many laborers in the field, and many now working there, if rightly organized and directed, would find a proper outlet for their energies and do their work better.

It is useless to turn to organized nursing as at present usually conducted, for that too, in spite of the examples afforded mostly in other countries, makes little or no provision for benefit payments (except through the Metropolitan).

In Chicago, all but 13 per cent of organized nursing work depends on contributions and is limited in amount by what can be so raised. Boston is a little better but not much, and St. Paul until recently was entirely charitable as to its organized nursing. These are types. This organized work was originally started as charity, and in spite of certain valuable demonstrations, its progress in getting out to the people has at times seemed hopelessly slow; it also needs the same remedy in the same way of distributing the burden through benefit payments.

As to the nursing and medical professions, the work of properly organizing the finances of therapeutic work in this country can hardly be put upon persons whose entire energies must necessarily be taken up by technical and administrative work. The most that can be asked of them is that they shall not insist upon impossible financial methods for accomplishing that which they wish to have done.

The point of attack is the business and financial people who are responsible for your hospitals and nursing organizations. What is needed from them is less philanthropy and check drawing and more of the business brains

that they give to other things. They must organize insurance and benefit payment, so that the people's needs can be met out of their own pockets. You should tell them that if they want young women to enter hospitals and become nurses, they must organize the finances of nursing so that she can do her work where she is needed when she graduates. They must do this just as they must reorganize the finances of their own hospital and surgery work, so that the ordinary independent citizen can pay for what he needs to have supplied. Otherwise—and they are beginning to know it—they will have the whole thing taken over by the state and thrown into politics.

There are signs of better things. I hope you will watch the Henry Street work in New York, and the Missouri Valley Hospital in Kansas City, where the attempt is being made to enable people of moderate means to finance their emergency service from their own pockets. In Brattleboro, Vt., where we have at the present time a highly developed system of service for a town and country district both for home and hospital, we hope to inaugurate a system whereby it will no longer be necessary to curtail service or to create financial distress in furnishing adequate service to each case.

There is only one way out. It is no more possible to supply the people with modern service in sickness by our present methods than to pay for their fuel and groceries by passing around the hat, or to expect them to meet the cost of occasional fires out of their current income. The whole therapeutic system is debauched by outworn charity traditions that impede its true progress, and a change is demanded. There is much money in the pockets of the people available for less important things, and it can be made available for this that is vitally important if we go to it. When the change comes I hope that the nursing profession will not let itself be left out of the going. I hope that it will be ready; and ready to lend a hand in the forming of local benefit associations to pay for hospital and nursing service, so that not only will the hospital and the specialist be provided for, but we shall have a graduate nurse available in every home when she is most needed.

#### WESTERN MEDICINE PROGRESSES IN CHINA

"Looking back over the past ten years," says Mr. Roger S. Greene, in his report as director of the China Medical Board of the Rockefeller Foundation, "it is clear that medicine in China has made real progress. The increased effectiveness of medical schools and hospitals, the development of an active Chinese medical association under enlightened leadership, and the growing interest of the Chinese people in Western medicine and public health, are sources of satisfaction to those who hope to see the Chinese people in possession of a scientific, well-rounded, and complete system of medicine."

Striking evidence that the pioneer work of foreign schools and colleges in China is bearing fruit is also found in the organization in 1921 of a purely Chinese national association.

#### TO SUPERINTEND MILFORD HOSPITAL

Miss Eileen Curley, former assistant superintendent of the Morton Hospital, Taunton, Mass., has been chosen superintendent of Milford Hospital at Milford, Mass., to succeed Miss Ellen Conrick, who has resigned and will soon marry Dr. J. V. Gallagher of that city. Miss Curley has been second in charge at Morton Hospital for four years. She is a graduate of the Massachusetts General Hospital, Boston.



## NEAR EAST RELIEF HOSPITALS IN CONSTANTINOPLE

BY ELIZABETH KNOWLTON, NEAR EAST RELIEF, NEW YORK, N. Y.

CONSTANTINOPLE—the very word suggests to us all the picturesque dirt and the crowded, unsanitary, colorful life of the Orient. But in this city of romance and refugees the Near East Relief has built up in the last two years a health organization that would do credit to any town in the United States.

Over two years ago an American doctor, Dr. Elfie Richard Graff, was asked by the Near East Relief to make a general survey of conditions and needs in Constantinople. At that time there was almost no work done for the poor and ill. There were several large districts where there were not even any native doctors to call upon. Now under the Near East Relief are a case work committee, three clinics and two hospitals.

The case work committee cares for the children of needy mothers, especially war widows. The native directress of each of its forty-four districts, before she gives aid of food or clothes, calls on the children in their homes, and refers those who need medical attention to the Near East Relief clinics and hospitals. This committee gave help to over 11,200 children in the last half-year.

Clinics conducted are divided into three groups, the adult clinics with almost 900 patients in six months, the child welfare clinics with 7,200, and the trachoma clinics with over 15,000.

Everywhere throughout its field of work the Near East Relief is valiantly fighting trachoma. That blinding disease always to be found in the Orient and accepted by the natives as something unpleasant but inevitable, like fleas, has lately, thanks to wars and deportations, become appallingly prevalent. All the conditions of refugee life encourage it—the extra dirt, the overcrowding, the malnutrition—and Constantinople is nowadays a city of refugees. So one of the two hospitals conducted there by the Near East Relief is a Trachoma Hospital.

### Grand Vizier's Palace Becomes Hospital

Hospitals in the Orient are not necessarily just like ours here. This one happens to be the former palace of

took the air in safe seclusion, are now the playground of 225 lively orphans.

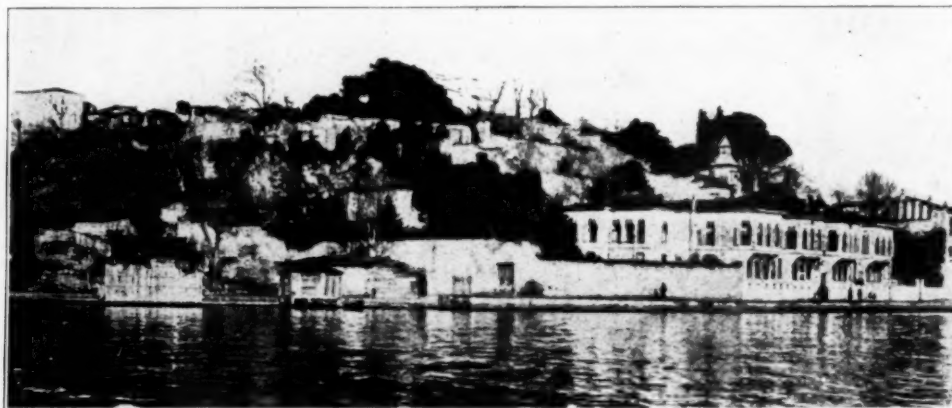
The Trachoma Hospital is under the supervision of Miss Emma Cushman, a woman of striking personality, the possessor of the Queen Alexandra War Medal, the Gold Cross of Jerusalem and the French Legion of Honor for philanthropic work. She is assisted by native nurses, trained for this work by Americans in the hospital. Their young patients represent almost all the nations gathered in that cosmopolitan city, Armenians, Greeks and Jews, Turks, Syrians and Chaldeans. For the Near East Relief takes children for treatment from all the national orphanages of Constantinople.

They live the lives of normal healthy children, except for the painful treatments which are necessary to cure trachoma. These come twice a day for each orphan; and every other day the American doctor comes and operates on those who would be benefitted. This is not to the children the terrible occasion that might be expected. It is told of one youngster who when examined was found in too poor general condition to stand the strain, that he went to bed that night crying, because he had been denied his operation!

### Little Patients Govern Selves

For the rest, the children have a busy, happy time of it. They work in the school which is conducted for them, help with tasks around the house and grounds, dig in the Grand Vizier's magnificent garden, and go swimming in the Bosphorus under their windows. It may be imagined that to keep in order 225 active children in fine physical condition is no easy job. So a canny plan of self-government has been evolved. The children are divided into groups of ten, and out of each group is chosen a leader. He is invested with a red armband, as badge of authority and honor, and is held responsible for the good behavior of this group. If he cannot keep order, he is removed and another leader appointed.

In general, there is surprisingly little "race rioting" for



The Near East Relief Trachoma Hospital on the shores of the Bosphorus, formerly the palace of the Grand Vizier of Abdul Hamid.

Riza Pasha, Grand Vizier of Abdul Hamid. It is situated just outside Constantinople on the shores of the bright-blue Bosphorus, a picturesque, rambling building with many windows, almost hidden from the land by the trees and shrubs of its famous terraced gardens. These gardens, where the ladies of the great Pasha's harem once

such a mixed lot, and what there is, the head puts down with a firm hand. "A Greek is no better than a Turk!" says Miss Cushman sharply, as she separates the warring parties, probably giving them both a good shaking in the process. "Remember that, children! A Greek is no better than a Turk! A Turk is no better than a Greek!"



American sailors at Constantinople give party to Armenian orphans at Near East Tubercular Hospital.



Greek, Armenian and Russian nurses at the Near East Relief Tubercular Hospital.

Life at the other Near East Relief hospital, that for tuberculous children, is of necessity more peaceful. There a third of the young patients are confined to bed, and many others hop around on crutches, as the most common form of tuberculosis with them is tuberculosis of the bones or joints, the indirect result of prolonged malnutrition.

Their hospital is less romantic than the other, and has a more medical atmosphere. Driving out of the Adrianople gate, you pass through fields of cabbages that make it seem like real country, till you come to the group of buildings that make up the Yedi Koule Tubercular Hospital. Before the war a Greek hospital, and now given to the Near East Relief, this institution is one of the best, in building and equipment, of any in the Constantinople district. The 115 children live in very modern-looking cottages, with screened sleeping porches where their beds are placed, and a big outdoor dining-room for the warm season. But medical equipment in the Near East is at the best not adequate. Though this hospital compares so favorably with most, it lacks many necessary articles, and they have to be improvised out of the materials at hand, as are the weights for a head or leg extension, which are made from American lard pails filled with sand.

This hospital, which is partly supported by Canadian gifts, has for its head Miss Emma M. Wood, a Canadian nurse, who received part of her training at Johns Hopkins. She has trained the nurses under her, Russians, Armenians and Greeks, who twenty months ago had had no experience. Now, she boasts, they "do all the nursing, make all the dressings, give the medicines and have entire charge of treatments and chartings, and are also able to put up either a head or a leg extension."

#### "Gobs" Scatter Happiness

The children here are a younger group than those at the Trachoma Hospital, very few of them being over twelve. In spite of deformed joints and twisted limbs, they are as happy, plump and smiling as any youngsters you often see. In fact, they are luckier than most little American patients, for they are the fortunate possessors of a countless number of fairy godfathers in the shape of American "gobs." Some American ship is always stationed at Constantinople, and the American Sailors' Club



Receiving guests at the Vedi Koli Tubercular Hospital

delights in giving them a good time. Every spring it invites all who are able to go, to the camp for a picnic, and last year seventy fortunate youngsters enjoyed a glorious day of games and "eats" with their sailor friends. At Christmas the Sailors'

Club played Santa Claus, and this Easter it gave the children money to make gardens, where poppies, daisies and pansies are flourishing, delighting their color-loving little souls. And frequently the long lonely days of the

sick children are cheered by visits from jolly "gobs," and by gifts of candy and toys. That the children are not lacking in gratitude for this kindness, defining gratitude as "a lively sense of favors to come," was shown plainly in a "thank-you" letter they composed, which ended with the naive expression, "We hope our sailors will be so kind as to make us enjoy on other occasions also. Thanks in advance!"

So, here as always, we see the name America winning love and affection from the people. Thanks to this feeling, the medical work of the Near East Relief in Constantinople and elsewhere is beginning



Washing the eyelids—a trachoma treatment. You would never guess from the patient pose that the treatment is extremely painful.

to bring to the natives the American taste for cleanliness and fresh air, and is teaching native nurses American methods of coping with trachoma, tuberculosis and other diseases. The work is carried on always with an eye to the future, and it is hoped that at an early date the Trachoma Hospital may be made unnecessary by the introduction of the modern treatment, with American-trained nurses to give it, into all the national orphanages, from which the hospital now draws practically all of its patients.



## THE HOSPITALS AND CANCER CONTROL

By FRANCIS CARTER WOOD, DIRECTOR, INSTITUTE OF CANCER RESEARCH, COLUMBIA UNIVERSITY, NEW YORK.

CANCER Week is announced by the American Society for the Control of Cancer to begin November 12. The motives behind this new movement in public health propaganda are extremely simple. They are based upon the fact that 90,000 people die of cancer in the United States every year, and that many could be saved by proper treatment; that surgery, radium, and x-ray are not at the present time very effective in late cancer and most patients consult their physicians at a stage in the course of the disease where all curative therapy is without avail and only palliative results can be obtained. If the people of this country can be educated to consult a doctor while a cancer is still early, many of them could be cured.

What can the hospitals do to help in the propaganda against cancer?

1. They can see to it that adequate histories are taken on cancer patients. An inspection of most hospital records shows that the histories of cancer patients, while supplying an abundance of unimportant details, are defective in many vital points. I have not been able to find, for example, in a very large series of histories, any facts which enable conclusions to be drawn as to the lapse of time from the first appearance of the growth to consultation with the physician, or what is also important, the time from the seeing of the physician until admission to the hospital. It is imperative for the control of cancer that these two periods be shortened as much as possible, but the histories are generally silent on the subject. Many patients have been treated by the dietary, physiotherapeutic or mind-cure quacks for months before consulting a physician. Such data are rarely found in histories, but are important if made public in leading to the possibility of some regulation or suppression of the irregular practitioner.

### Should Keep Slide as Record

2. The hospital authorities should provide for the routine microscopic examination of all pathological material. A not inconsiderable proportion of the lymph nodes exercised from the neck and diagnosed as tuberculosis are really cancerous. Ulcerative lesions of the bowels thought to be merely inflammatory are occasionally malignant. Frequent slips are made in diagnosing borderline breast tumors. In many cases a carcinoma of the uterus is not found because the curettings or similar material removed in the operating room are not submitted to a microscopic examination. Not only the diagnosis, but also the prognosis, depends greatly upon examination of the tumor material removed. It is the duty of every hospital to see that all these examinations are made, and that a microscopic slide is preserved from every case. The slide record is much more important than a long and wordy description of microscopic findings.

3. Hospital authorities should do everything they can to encourage autopsies. The present low recorded death rate from cancer in the United States is due partly to the fact that many obscure abdominal cancers escape diagnosis. Within the past year I have seen four cases of carcinoma of the stomach which failed of diagnosis by some of the most expert physicians in the city of New York only to be revealed at autopsy.

4. The hospital should see that cases of cancer are reported, as such. The family too often asks that the diagnosis of cancer be not written against the patient's name, but that a terminal pneumonia or some other immediate cause of death be placed on the certificate. The practice should be frowned upon.

5. The establishment and development of follow-up clinics are exceedingly important in regard to the ultimate result of the operative work of cancer. In the larger cities the surgeon is too often liable to retain an optimistic attitude toward his operative work on cancer because he loses sight of his patients. The follow-up clinic which brings patients back for observation for a considerable period will often show the results are not as satisfactory as they promised. The best adjunct of the follow-up is a radio-therapeutic clinic because the patients who receive post-operative radiation feel that they are getting some care from the hospital itself, and hence are much more likely to return for post-operative raying, and the end results are determinable. Such clinics can be made self-supporting.

6. The social service nurses should have impressed upon them the importance of spreading the simpler facts concerning the nature of cancer. They come in intimate contact with the families of patients and are often in a position to make a tentative diagnosis. They should attend the lectures of the American Society for the Control of Cancer, and obtain the necessary literature by writing to the society, 370 Seventh avenue, New York, and familiarize themselves with the methods of spreading proper information concerning cancer.

7. The attending staff of the hospital should conduct diagnostic clinics on cancer both during Cancer Week and at other times, not only for their own intellectual profit, but also in order to educate the house staff and instruct the physicians, who send their patients to the hospital, in the modern methods of diagnosis and the results of modern therapeutic methods as applied to cancer. It is not easy to tell a brother practitioner that he has been worse than a fool to treat a cancer of the breast by diet and massage, but it is easy to demonstrate the fact if the patient is shown in a clinic.

8. So much for those patients who are within the doors of the hospital. The saddest sight is the patient who is turned from an institution because a cursory examination has led some recent graduate to decide that he is inoperable. This should not be. Many cases which have been refused admission and told vaguely to go somewhere and take x-ray or radium, naturally feel that there is no hope and drift into the hands of the ever-present quack. Many of them are really not operable. The determination of the operability or non-operability of a case of carcinoma is often a matter of the most careful judgment and should be referred to some senior member of the staff. If operable, the patient should be given a letter referring him to some institution where proper palliative radium or x-ray treatment can be carried out, assuming that the hospital itself has no such facilities.

"The basis for all publicity is the usefulness, need and value of the thing advertised. Our apologia must be sound and convincing."—RALPH WELLES KEELER.

## NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,

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### THE ROLE OF THE HOSPITAL NURSING DEPARTMENT IN THE COMMUNITY HEALTH PROGRAM\*

By ANNIE W. GOODRICH, R.N., DIRECTOR OF NURSING, HENRY STREET SETTLEMENT, NEW YORK CITY.

I SHALL have to ask to deal rather with the role of the hospital, than the hospital nursing department, in the community health program, for the part of any department is inevitably bound up, or certainly to a very great extent dependent, upon the policy of the whole.

Further I must add that I am suffering from a profound awareness of my inability to present in other than slightly differing phraseology what has been said forcefully, frequently and convincingly by the various specialists in the new field of preventive medicine, beginning with the public health nurse whose maiden speech dealt with the inadequacy of the hospital training for the field of public health nursing.

Each in turn has been convinced, and rightly, of the need of every practitioner of medicine and nursing of first-hand knowledge of their specialties and a broader interpretation of their function in the health field at large until we have reached a final summing up of the discussion in the exhaustive analysis of the Rockefeller-Goldmark report on nursing education—its weaknesses and strengths—on the one hand; and on the other, the briefer but broad conception of the hospital function in the health movement through the report on the principles of hospital administration and the training of hospital executives by Dr. Willard C. Rappleye.

#### Society Still Indifferent to Health Needs

There are some who do not agree on the importance of the hospital in the new health conception. For ourselves, it matters not how intense or intelligent is our appreciation of the new outlook on health sublimated recently into the term "positive health," or that we are in complete agreement on the importance of approaching the subject of health from the normal rather than the abnormal standpoint; nevertheless we still have to deal in the matter of the health of the community with certain facts, such for instance as:

a. The tendency of all normal individuals, rich or poor, to be indifferent to the subject of health until rapped into attention by the handicap of some defect, personal or with some individual with whom they are concerned.

b. That the prevalence of defects has brought all classes of society to recognize, even to demand, the service of those health agents designated as physicians, nurses and dentists, this fact giving these practitioners the opportunity of wide and frequent contact and the advantages of accepted authorities

c. The defectives in any given unit of population increase in almost direct ratio with the decrease in the wage scale which connotes a decreasing body of knowledge (I refuse to say intelligence) as well as opportunity concerning the procedure necessary to change the situation. "The destruction of the poor," said Solomon, "is their poverty."

d. Only a comparatively small number appear to be ready as yet to subscribe to the practice of preventive medicine, even though believing in the theory. Evidence of this may be found in the failure to support such measures as the Sheppard-Towner Bill, or the peace program of the Red Cross, and in the still general habit of institutions and organizations, primarily concerned in the care of the sick, to limit their function to a given situation and to fail to assume the responsibility of health education relating to such a situation.

The following illustrates these facts:—The young wife of a professor called for advice and assistance concerning her new-born baby that had cried all night. She stated that she had just returned from the maternity hospital and that she was totally ignorant as to the child's care, such as bathing and diet. She had called the visiting nurse service and was told that it was impossible to send a nurse as the organization was obliged to give precedence to sickness cases, and the daily program was more than filled.

In this episode we have an almost complete picture, the young mother not alertly seeking information before leaving the institution. Not until something went wrong with the baby did she awaken to her educational needs, while the hospital and the visiting nurse service were functioning in exact accordance with the tenets of curative not preventive medicine.

The preceding facts seem to me to summarize as follows: the prevalence of defects; the place in the family life accorded physicians and nurses by a society still indifferent to its health needs; the scientific equipment as expressed in hospital machinery and personnel now required for the effective dealing with defects; the increasing use of these institutions for the maternity case; and their continued and extending use as laboratories for the preparation of health workers of varying types. All of these things demand that the hospital, of strategic importance in health problems, function either as the health center within a given area or at least as a definite link in the chain of health activities required for a community health project. To do this effectively, however, will necessitate reconstruction of its program, method and system.

Mr. Bailey Burritt of the Association for Improving the Condition of the Poor in writing on "The Family as a Unit in the Control of Disease" opens his paper with the statement that "public health nurses and public health authorities must increasingly take the family into account

\*Read before the twenty-fourth annual conference of the American Hospital Association at Atlantic City, N. J., Sept. 25-28.



if we are to hope for further substantial reductions in morbidity and mortality rates, and particularly if we are to hope for marked progress toward the goal of making every individual a strong, healthy, able-bodied citizen over a considerable period of years."

### Family the Unit of Responsibility

Making of the family the unit of hospital responsibility, if consistently carried out, will require that the entire personnel of the institution shall experience that life within its walls that will most effectively and enduringly impress upon them the essentials in health habits for their personal life, not less than for the lives they are directing or being prepared to direct.

One is tempted to digress, if digression it should be called, to discuss the changes that would immediately be effected if the hospital interpreted its case responsibility as extending to its large and varied personnel and in the terms of the family rather than of the individual.

The consideration and direction, for instance, of the life of the interns, their hours, their housing, their diet. I recall a recent recital by an overstrained intern of consecutive days and nights of service with its attendant complications of sleep and food, and my mind is crowded with memories of conditions reacting disastrously upon the patients as well as the hospital personnel, which a health program for all might have averted.

The assuming of the family as the unit of responsibility would bring about other much needed adjustments, the most outstanding of which would be the limitation of each hospital's functions to a given area or unit of population with a resultant coordination and correlation of all health agencies, educational or remedial.

Progress in the direction of this unification idea there has been. The slow but steady development of central schools of nursing, the growing relationship between the school of nursing and the university, the increasing cooperation between social and health organizations, the numerous experiments, such as, that of Framingham and Mansfield, are definite achievements toward this end, but in relation to the output of convincing presentation of the need as expressed by progressive social and health authorities, and in the face of the possibilities for rapid and great achievements through complete unification of means and ends, they are agonizingly slow and intolerably aloof.

It has been said that "the real task for workers in the field of mental hygiene is translating insight into influence," so also might it well be said concerning the task of all health workers, for despite these evidences of progress almost incredible situations exist through a failure to act in terms of community development and well-being.

### Sees Folly in Sending Students to Distant School

In the light of present-day knowledge surely a local situation is astounding that results in sending students of a school of nursing in a state having a population of 2,500,000 (which would represent approximately 1,000,000 children) to the eastern coast year after year for a course in pediatrics, or in sending students in a city having a population of approximately 700,000 (which means over 14,000 births yearly) to an adjoining city for a course in obstetrics. One hesitates to call attention to these facts lest students be withdrawn from the distant institutions and thereby lose the opportunity of an essential experience, but, on the other hand, the loss to the locality of needed service and the economy of time and money which a different adjustment would mean demands careful consideration and a speedy solution of the problem.

1. Public Health Nurses' Bulletin--August, 1922.

In one city of something over 200,000 which means approximately 100,000 children maintaining several schools of nursing, with the exception of one school, almost none of the students was receiving a course in pediatrics. The one school was sending its students for a month's experience to another institution. It was true that the infant mortality in that city was low, but on the other hand, in its two tuberculosis sanatoriums were to be found a rather large number of children ranging anywhere from one to fifteen years. The heaviest age group in its state hospital for the insane was from twenty to twenty-five years. There was one institution for children with an approximately fifty-bed capacity mainly for orthopedic cases but that had enlarged its service to include medical cases, and was doing rather an interesting piece of work with syphilis.

Students are deprived of experience, or service is not rendered, mainly because of a wrong point of view as to the relation between these organizations and institutions and the community at large, the keynote of which is struck in the still frequent phrase, "our school, our patients, our family." What creates ownership of students, of patients, or families? Education for which the students pay in service or money, sickness care rendered to a particular member, relief given for a particular case.

Born of philanthropy rather than coming into existence through the felt need of the members of the community, these organizations and institutions, finest flowers as it were of a passing system which have indeed sown the seeds of the new social order, nevertheless to serve effectively, indeed to survive in a democracy, must know themselves to be responsible to the community, not for the community whom they serve. Their roots today must be sunk deep in *conscious community ownership* in order that they may receive the support—moral and financial—for effective functioning.<sup>1</sup>

### Cooperative Health Insurance Schemes

Here too, in the matter of financial community support we can also strike an optimistic note for we find evidence of development; in the most experimental stage, it is true, but nevertheless quite definite.

In a recent issue of a magazine called *Cooperation*, we find the following:

"Since 1904, the workers of Madrid, Spain, have maintained a health department in the cooperative society (La Mutualidad Obrera). This provides complete medical service for eight dollars a year for each member. There are seven clinic-hospitals in different parts of the city, each equipped with about ten beds, an up-to-date operating room, a dental clinic, consulting rooms, an immaculate tiled kitchen, and a garden for convalescents. Each has a staff of physicians, surgeons and nurses. The drug store connected with each hospital furnishes medicines free of charge to the members, and sells to non-members at the current price. The cooperative society supplies the hospitals with provisions. Each member pays 66 cents a month to the society. For this, besides the benefits of membership, he receives free medical service, major operations, consultation and advice at any time."<sup>2</sup>

Again in the city of New York under the title of the Manhattanville Health Society an experiment<sup>3</sup> of this nature is being carried on based on the computation of three organizations that their service is subscribed to by 5,000 people could be supported at the rate of \$6.00 per capita subscription.

We are quite confident that when the hospital assumes the place in the health program which Dr. Rappleye has so justly assigned it the many greatly needed readjustments will speedily follow.

"Position of the Hospital—The common ground upon which the patient, the community and the professional groups meet and represent—

2. It is the author's belief that an effective transfer from philanthropic to governmental support is not possible because of the present tendency to control through symbol rather than *intelligent* common consent: the subject of symbols has been ably dealt with by Walter Lippman in *Public Opinion*, Part 5.

3. *Cooperation*, October, 1922.

4. The plan for this health project was evolved by Ella Phillips Candall, recently executive secretary of the National Organization for Public Health Nursing, and is subsidized by an unknown donor.

ing the general type of organization which, with proper amplification and development, can best meet the problems suggested, is the hospital. It evidently occupies a strategic mid-position and has open to it a great opportunity and a corresponding obligation, not as an institution for the salvage of human wreckage but as a coordinator of activities—professional, economic and social—in their application upon the problems of health. In such a conception, the hospital represents not the administration alone but a cooperative organization of workers and leaders devoted to the ideals of their respective professions."<sup>5</sup>

The tendency of physicians and nurses to overemphasize the physical aspects of the case, with their resulting disregard or minimizing of the social factors directly affecting it, has been advanced as a distinct handicap in their effective functioning as health workers. This has been given indeed as one of the important reasons for the creation of social workers without medical or nursing training. A careful consideration of the question leads to the conclusion that, while fully accepting the fact of this tendency and also the place in the health program of this type of social worker, this is not the best solution of the difficulty.

### Social Training of Health Workers

The purpose of a hospital or dispensary is to meet the need of physically or mentally defective individuals whatever may be the contributing or underlying cause of such defects. Beginning with the chief executive down through the various departments wherever the medical situation dominates there is definitely required a medical or nursing personnel. In the cause of effective and economic service, such personnel should be relieved as far as possible of the non-medical features of the case through the service of other workers skilled in such features; not less also in the cause of economic efficiency should the medical workers be expected to have such knowledge of the non-medical aspects of the case as to understand the importance of their relation and furthermore to deal with such aspects where the body of the work will not justify the two specialists.

This implies a knowledge of the technique of case work for both physicians and nurses. It will very possibly be taught more effectively by a social worker than a physician or nurse but whoever teaches the subject, let me add, will probably do so with better effect if prepared through a course in teaching methods. The same could be said concerning the technique or the science, for such it has come to be, of administration. Such knowledge should be required of every administrator today, but to select a physician merely because of such knowledge to administer a business house or to select a business man to administer a hospital is, we believe, poor judgment because of the waste of medical knowledge on the one hand and the handicap of the lack of it on the other. It would, however, be equally poor judgment to appoint as the chief executive for either position a person with a predominantly research type of mind. In the personnel of the business concern of today would probably be included physicians and nurses while the personnel of all modern hospitals includes nutrition workers, statisticians, librarians, accountants, engineers, and an almost endless variety of medical and non-medical workers.

In short, the purpose or function of an institution should determine not only the type but the relation and distribution of its personnel. Whatever may be the process or processes through which the result sought may ultimately be effected, it is desirable that a person seeking such result through an institution created for the attainment of that end should be as immediately as possible related to those whose discernment in the matter has been "sharpened to a point" through training and experience. The failure to appreciate the importance of such adjustments

has been and still is one of the outstanding weaknesses of hospitals and dispensaries due mainly to an inadequacy of funds and ipso facto an insufficient and inefficient personnel.

The introduction and rapidly increasing number of private patients, since *their* demands must be given consideration, have been beneficial but the overcrowding and understaffing of departments, such as dispensaries and public wards still obtains. Personally we do not believe that the development of new types of workers is needed so much as the provision of a different and broader content of education for the medical and nursing personnel and the use for their respective specialties of a sufficiently large and varied staff to enable courteous and intelligent investigation and direction through the now labyrinthine procedure of every case.

Since health provides a great, possibly the greatest common denominator, I conceive that the professional or special preparation of all types of health workers should be based on as similar a body of scientific knowledge as possible in order not only that there shall be a complete current of understanding between the workers representing the three essentials—research, education, and practice—but *because constructive functioning in a creative scheme demands of every worker a modicum of each.*

For the nurse, and it is with her function that this paper is especially concerned, I believe that this underlying body of science should be of college grade and should be obtained through the first two years. Following this, she should have not less than two, and better, three years of hospital experience. The value of the hospital as a laboratory cannot be too greatly emphasized. The congregation and variety of cases makes possible in a few months an experience that it would take otherwise years to obtain, but in this bedside experience should be included mental diseases, tuberculosis and diseases of children. Furthermore, definite and comprehensive experience should be given in obstetrics and adequate experience as well as instruction in normal child life. The period of case experience should be of sufficient length and continuity to fix impressions and enable experimentation for the end result.

Of the greatest importance in this scheme of education will be the acceptance by the hospital of the family as its unit of responsibility. The fact that the hospital wards represent but one piece of the machinery in any health program, that the dispensary and the health station with their varied and adequate personnel, and even the home, the occupation and the recreation of the individual case, are part of this project demands that case technique, not less than case experience, shall be included, and these throughout the professional preparation of the nurse. There must be such provision of paid staff for the care of the patients as will enable each student to secure a complete cycle of experience and a reasonably close correlation of theory and practice as expressed in nursing procedures, problems of nutrition, etc.

### Requirements for Teaching Staff

The selection, the function, even the daily life of the staff or faculty, are not less important matters for consideration than are the problems relating to the student life. Briefly summarized, the outstanding essentials for this group are as follows:

- a. A broad general and professional preparation. Specialization in each and every department or subject. An adjustment of time that will insure the essentials mentioned for a constructive program—research, education and practice—their proportionate part.
- b. Opportunity for enlargement of life through a varied experience, such as rotation of executive and teaching experiences, group con-

5. The Principles of Hospital Administration and the Training of Hospital Executives, p. 10.



ferences, exchange experiences with other institutions and organizations.

c. The placing so far as possible of all personnel directing the various phases of the health movement on the executive and teaching staff of the school.

d. Free discussion and participation in determining all questions relating to the organization and administration of the school, its laboratories, the hospitals and, as far as possible, outside organizations with constant emphasis on the inter-relations of all persons and departments concerned in the project.

Finally, the hospital as an exponent of health should provide for its entire personnel sanitary surroundings, adequate and suitable diet, and a properly proportioned

daily life from the standpoint of occupation, intellectual development, recreation and rest.

Such a program, such a policy, on the part of the hospital through the educational force of example would result in a steady outpouring into the stream of life, workers whose deepened sense of social responsibility not less than their scientific intelligence will permeate the social structure and will accelerate immeasurably the community health and well-being which we are seeking.

## THE USE OF WARD HELPERS\*

By S. LILLIAN CLAYTON, R.N., DIRECTOR OF NURSING, PHILADELPHIA GENERAL HOSPITAL, PHILADELPHIA, PA.

**B**EFORE we can discuss the use of ward helpers, we must be sure we understand the meaning of the term. We speak of the ward helper, of the ward maid and of the attendant; but it is important that we do not use these terms interchangeably.

Upon investigation, we find that hospitals have not settled upon any particular outline of duties, hours, salaries or training for these three groups of workers; and because one finds in various institutions representatives of these groups having somewhat similar duties but performing them under different titles, this paper will not be confined to the discussion of the one type of worker—the ward helper.

### Three Classes of Workers Defined

For the sake of presenting the subject clearly, we will understand the *ward maid* to be a person employed by the hospital for the purpose of performing general domestic duties in a department. No previous training and no educational standards are required, except such standards of personal integrity and faithfulness to duty as would be desired in a servant wherever employed. The salary and hours should be such as prevail in any given locality. The same reference should be required as would be expected in a home upon the employment of a servant.

The second group of workers, we will term the *ward helpers*. This group should have more intelligence than the first group. No particular educational standards need be required, except that its members speak and read the English language. Their personal appearance and conduct should be such as to be acceptable to the patients. They should receive no training, nor should they have duties that could in any way be interpreted as nursing experience. Their hours and salary should be the same as those given to the ward maids, or perhaps the salary might be somewhat higher. Their position as ward helpers should not be considered as experience qualifying them in any way to serve the public in the care of the sick, whether the sickness be acute, convalescing or chronic.

Among the duties they may perform are: dusting, cleaning utensils, caring for linen, arranging flowers, taking patients to sun parlors, x-ray laboratories, arranging trays, feeding patients, etc.; in other words the duties of these workers are not fixed. The three important points to remember are that the workers are employed as workers, not learners; they receive no instruction; and the result of this experience will in no way prepare them for the care of the sick, nor should they expect it to do so. In order that there be no misunderstanding as to this, thereby causing discontent and friction, they should be thoroughly acquainted with these facts before being employed.

The third group of workers we will for the present, term *attendants*. These women should have completed grammar school; they should be properly qualified physically and personally; they should receive from the hospital maintenance, uniform and a small allowance.

A carefully prepared outline of training both practical and theoretical should be given, covering eight or nine months. At the end of this term, they should receive a certificate and should be ready to leave the hospital. If they remain after the completion of their course they should receive a salary. This salary should be determined by the standard of salaries in a given locality. Hospitals desiring this class of workers and not giving a course for attendants should employ them as stated above.

The content of such a course should be determined by a state board of examiners for registration of nurses. The type of institution in which this training may be given should be determined by state laws and the worker and the patient should be protected by proper legislation.

The use of these groups by any given hospital will be determined by its type of patients, its economic necessity and by its interpretation of its own function in the community. The hospital believing that it has an educational function in the community, therefore desiring the most scientific care for its patients will provide a personnel making such care possible.

Ward maids and ward helpers will be employed in such numbers as to make possible the use of all scientifically trained persons to the best advantage. Persons who by virtue of their high grade of intelligence, personality, training and experience have been employed for these services will be detailed only to the actual care of patients, and to the making and recording of scientific observations. This applies to graduate and to student nurses.

This will be an economical policy also for by so doing, the course of training for the student nurse can be shortened and the graduate nurses employed will be fewer in number, for their time can become concentrated upon the patient, his personal and scientific care. The same hospital will employ trained attendants for such patients as do not need the time of the student nurse or of the graduate nurse. In this age of specialization all of these workers may have a place.

### All Three Groups for Chronic Hospitals

In the hospital caring largely for chronic patients, all three groups of workers can be employed with a sufficient number of graduate nurses to make the care of the patients safe. Again, specialization will promote economy in administration, as well as making safe and scientific the care of the patients. The adequate use of these three groups of workers in hospitals is largely a matter of education and of adjustment.

We have spoken briefly of the meaning of these different

\*A paper read before the twenty-fourth annual conference of the American Hospital Association, Atlantic City, N. J., Sept. 25-28.

groups of workers and of their uses. We would now speak of two important points to be considered by those who desire to introduce these workers into their organizations.

(1.) What obligations do any such organizations have to these workers?

(2.) What obligations do any such organizations have to the public in making it possible for these new types of workers to assume responsibility for the sick in the community?

In answer to the first question, the organization admitting these groups should know that it can do so without exploitation. In the case of the first two groups, proper working hours, living conditions and fair salaries will prevent any such accusation. It might be added that it will be a great advance in hospital administration when welfare departments are considered a necessity.

Hospitals are increasingly being placed on a business basis; they are becoming intricate in their organization and administration. Because of this, they should consider the welfare of their employees. All too often they are concerned only with the welfare of the patients and of the nursing personnel.

In the case of the third group, the responsibility of the hospital lies in being able to provide the proper working and living conditions; in planning for and carrying into effect the outline of training promised; in providing the proper supervision while this training is being received; in using all its influence to secure proper state laws for the registration and supervision of these workers after graduation, and last but not least in absolutely refusing to prepare such a group of workers unless it can be done in perfect fairness to the group, to the patients and to the public.

In considering what obligation any organization has to the public in making it possible for these new types of workers to assume responsibility for the sick in the community, we must consider:

(1.) Not to employ more helpers in the hospital than are needed in the performance of their particular duties. By doing otherwise, these workers will eventually assume nursing duties, which will lead to a misrepresentation of themselves to the community, and later render them dangerous factors to public health. The institution must not make it possible for them to imitate nursing procedures which they are incapable of performing scientifically, resulting thereby in reducing the patients' faith in the hospital.

(2.) In the case of the patient in the hospital, no one, regardless of his financial standing in the community should be subjected to the care of this group if critically ill, for there will exist a lack of confidence on the part of the patients, and their well-being may be seriously affected by the lack of necessary intelligent care.

(3.) If attendants are trained, the hospital should consider it necessary to have as satisfactory a reputation for its attendant school as it would for its nurses' school.

(4.) Hospitals should refuse to train attendants until the necessary legislation has gone into effect, making it impossible for the medical profession and the public to employ them under any misrepresentation as to their preparation.

The trained attendant is a necessity, but if she is really to perform her function in society, the following principles must be adhered to:

The proper course of training must be decided upon as to content and duration.

The proper provision must be made for her living and training.

The proper laws must be made as to the conditions under which she shall practice.

This type of worker has been tried in many hospitals, private homes and public health organizations. There is no question as to her value, but this value has been limited because the principles, as stated above had not been observed.

This brings us to the recent report made by the committee appointed by the Rockefeller Foundation to make a study of the nursing situation in this country. I wish to refer to that part of it which considers the "field for a subsidiary type of nursing service."

In this section we find that private physicians, health administrators and hospitals need two types of nursing service, emphasizing the fact that these two types should be provided, according to the type of illness and not on economic grounds.

The latter "economic grounds" is questioned by this committee, for it has been found that the margin between the average annual income of the private duty nurse and that of the domestic servant, is not so great as to permit the existence of an intermediate grade on a salary level very much below that of the present registered nurse. This committee recommends these workers for the mild or chronic and convalescent case. It further reminds us that of the 300,000 male and female nurses in the United States, more than one-half are of grades below the standard of the graduate nurse. This class of workers is a real fact and it fills a real need.

The nursing profession has discharged a fundamental duty to the public in stimulating the development of registration laws, which define and delimit practice of the profession and which protect the community against fraud and exploitation by those who collect fees and assume responsibilities to which their qualifications do not entitle them.

In addition to the registration of the trained nurse it is essential that the lower grade of nursing service should be defined and registered. The committee recommends that the name of this group of workers be *nursing aide* as it meets the need for clear differentiation while providing the subsidiary worker with a suitable name. With the two distinct grades of service available, the individual physician would be responsible for the choice of a trained nurse or a nursing aide in a given instance.

The public can only be safeguarded in these matters by state legislation for the definition and license qualifications of each nurse or nursing aide furnished.

The committee's conclusion of the matter is "that steps should be taken through state legislation for the definition and licensing of a subsidiary grade of nursing service, the subsidiary type of worker to serve under practicing physicians in the care of mild and chronic illness and convalescence, and possibly to assist under the direction of the trained nurse by certain phases of hospital and visiting nursing."<sup>†</sup>

In conclusion, we beg to state that we believe the ward helper and the nursing aide or attendant can best be used in our effort to carry out the ideals of adequate nursing care for all the sick public, under conditions mentioned earlier in this paper and voiced in a different way by the Rockefeller Committee. If the American Hospital Association and the nursing organizations unite their efforts and have the same objective for the use of these workers, we believe that much of our present problem as to how to supply adequate care for the sick will be solved.

<sup>†</sup>The above statements referring to the Rockefeller report were taken from Miss Goldmark's report of the work of that committee.



## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,  
Supervising Dietitian, Mt. Sinai Hospital, New York.

### THE RELATION OF THE HOSPITAL AND THE CHILD: A SUGGESTED SOLUTION\*

By FRANK HOWARD RICHARDSON, M.D., CHILDREN'S DEPARTMENT, BROOKLYN HOSPITAL, BROOKLYN, N. Y.

**I**N THIS discussion, I am more concerned with minimizing the time to be spent by the child within the hospital, than in considering how he shall be fed while he is there. In other words, the needs of the hospital as related to the child must constitute our sole criterion in considering every aspect of our problem.

It is only fair to face the fact that the children's hospital and the children's ward, as constituted in most places today, are really on trial, and are called upon by thinking folk everywhere to justify their existence, or at least their existence under ordinary conditions as we meet with them.

#### Has Hospitalized Child a Fair Deal?

The ideal relation existing between the hospital and the child has long been a subject for keen debate. It used to be generally accepted that there was nothing better for any sick child, whether rich or poor and of whatever age, than to be subjected to the regular, steady regimen of the life of the hospital ward, with its carefully regulated diet, its freedom from excitement, and its cleanliness and perfect sanitation. It took some of the horrifying statistics of some of the big institutions which care for children, with their 100 per cent mortality rate for infants who stayed long enough in their wards, to jolt us out of this complaisant mood and to make us wonder whether such mortality records could coexist with a fair deal to the hospitalized child, no matter how beautifully white the walls and the beds of such wards might be. Such figures as these, and they can be matched without much trouble today wherever infants are brought together in wards and kept for any length of time, cannot be gainsaid; it is admitted by us all that the bottle fed baby fares wretchedly even in the best of wards.

And yet not every pediatrician is willing to go so far as does Chapin, for instance, in feeling that every institution for the care of children, except those providing only the most transient and transitory care, is a curse to the child. Of course, "hospitalism" as seen in the wan, listless infant who refuses to thrive on any mixture, no matter how well-adapted theoretically to his needs, or as seen in the "good" child of the oldtime orphan asylum, with his uniform clothing, his lockstep play, and his

brooding air of detachment and lack of interest in life, is going to find no defenders today among thinking people, especially among such a gathering as this. But is even the possibility, much less the probability, of such a commonly observed phenomenon, for instance, as cross infection, not enough to render the admission of a child to a hospital ward at least a very real hazard to which we must subject that child only after determining that the gain is far in excess of the possible harm? As serious students of the hospital problem in all its bearings today, it behooves us seriously to consider and weigh the "pros" against the "cons"; to evaluate both, justly, in order to arrive at a conclusion which shall be satisfactory to us as hospital specialists and as human beings.

First, then, the "pros," which are not only manifold but plainly manifest, and seem to admit of no denying. Certain conditions one thinks of offhand: such are surgical procedures practically impossible of accomplishment outside of hospital walls; the nursing problem with its excessive financial drain upon the purses of even the more than moderately well-to-do especially in such long-drawn-out cases as typhoid, or some of the surgical infections; the exigencies of such a treacherous, fulminant disease as pneumonia with its demands for constant attendance and constant alertness on the part of both doctors and nurses; the sudden deprivation of parents, either by death or by disease or accident, with its consequent temporary "boarding" of the well child in the ward; all of these seem to constitute almost insuperable reasons for the hospitalization of children (using the term here in its original and best sense).

The "contras" have been hinted at above. The appalling death rates of infants in even the best-regulated of infant wards, if they remain there for any length of time; "hospitalism" in its worst sense, a condition that no clinician or experienced nurse needs or cares to have called to mind with its picture of unavoidable and early dissolution stamped on the tiny faces of its victims; cross infection, that bane of everyone who deals with children in institutions; the frequency with which a child well on entering the institution (the so-called "boarder") becomes a sick child before leaving; the marked reluctance of parents of any social or economic status to give up the care of their children unless absolutely unavoidable; the usual extreme terror of the average child at the mere

\*Read before the section of dietetics at the twenty-fourth annual conference of the American Hospital Association, Sept. 25-28.

mention of the separation involved in hospital admission; the mental effect upon the child of the sights and sounds of a hospital, with the inevitable resultant psychic trauma and scar; the unnecessary expense of detailing in the hospital for long periods of time with the well known high per diem expenditure, such cases as long-drawn out orthopedics, interval or terminal convalescents; and the consequent occupation of beds that should be available for really acute cases—all these constitute the other side of a picture that at times seems to present an overwhelming case for the negative, too depressing, not to say uneconomic, to be allowed to continue.

### Finds Way Out in Out-Patient Department

What then are we to do? What can be suggested as a possible solution of the problem? Can we fairly and truly say that the hospital treatment of children is out-of-date, as Chapin virtually does; and lives out his conclusion in the establishment of his wonderful system of Speedwell Orphanages, where the children and infants are boarded or adopted out, with only the shortest possible detention in hospital on the way? Or shall we say that the children's ward, as ordinarily conducted, has been with us always and must always continue as it is? Or is there perchance some middle ground which we can find, and on this erect our structure?

My own belief is that we have ready to our hand, although so far not very widely utilized to its fullest extent, an agency that offers the ideal solution of this very real hospital problem. This agency is that properly conceived and properly run out-patient department, with its logical appendage, the nutrition or health class. For such a department is nothing more or less than an amplification of the children's ward, with a multiplication of its opportunities for service; which takes over every conceivable phase and function of the children's ward except such as absolutely demand the facilities offered by the ward, and not available elsewhere.

I am, of course, speaking here of the out-patient department which is staffed by the identical men who compose the intramural staff of the children's department, and which functions as an integral part of the pediatric service, with a single record that passes freely with the patient from clinic to ward, and vice versa, as circumstances vary and inside treatment becomes imperative or ceases to become so, and outside care becomes possible. I am, of course, barring out from discussion the more usual conception of a children's clinic—as a nuisance imposed upon the juniors of the service, to be pushed by them, if possible, upon the shoulders of young practitioners not connected with the hospital staff who do not know any better than to be thus imposed upon.

Under such a perfectly coordinated system as we are supposing, supplemented by the cooperation of the up-to-date social service department, every case is carefully and fully studied while at home, and every appropriate diagnostic aid is applied before the child is asked or allowed to enter the hospital. Many an actively, even desperately, ill child may never need ward care at all. If, however, a hospital sojourn proves unavoidable, it is reduced to its shortest possible extent for it does not begin until the latest possible moment and is terminated the very moment the child has recovered sufficiently to be carried home in its parents' arms and brought back to the clinic for follow-up work. There is no break in continuity of attendance as the medical attendants are the same outside as in the ward; the visiting nurse takes over the functions of the ward nurse; and special diet, where needed, is directed, supervised, and if necessary provided, by the social

service department. Return visits are secured as a matter of course; for even quite seriously ill pediatric cases may be handled as ambulant cases, both before and after their stay in the ward, in the sense that they can safely and easily be carried to the clinic, whereas equally ill adult patients could not be so handled. The fact that the same doctors who made the first contact with the case, studied it before its admission, and carried it through its sojourn in the ward, are the ones who will go on with the conduct in the out-patient department, render such return visits almost a matter of course.

That most useful appanage of the out-patient department, the nutrition class, carries all these advantages to the nth power. For here we already have in operation the nearest approach to the ideal of preventive medicine that has so far been made available for general hospital use in a community. Here we have at work the machinery for giving the child, before acute illness comes upon him, the complete, all-round, searching examination that the life extension institutes have rendered available for adults—the inter-departmental liaison, if you will, that alone can adequately provide an examination so much wider in its scope than medical pediatrics alone is prepared to give. Here we have, too, the confidence in the doctors born of intimate friendly acquaintance with them in time of health; the familiarity with the hospital, the nurses, the dietitian, the social service workers and volunteer aides, growing out of the happy times spent at the weekly sessions of the nutrition class, with its games, its fun, and its frolics; and the realization, early impressed upon every child and every parent, that immediate treatment of every symptom, whether serious or trivial, is the only safe and sensible course. All these conditions combine to make an ideal patient, in an ideal frame of mind, whenever entrance into the hospital does become necessary.

It goes without saying that such an ideal milieu for the hospital patient exists only in the hospital whose out-patient, pediatric department is an integral part of its children's service, such as has been sketched above, with identical staff, single record, and absolute ease of transfer from out-patient to in-patient service, or vice versa, as occasion may require. How simple and rational such a condition of affairs seems; and yet how rarely is it to be met with in actual hospital practice! I venture to go to the logical limit implied by what has gone before and say that the hospital which lacks such a coordinated children's department is wasting the money entrusted to it by its donors, is depriving needy children of bed space that they should have, and has no right to attempt to minister to children at all!

### Urges Use of Certified Milk for Babies

I cannot close this paper without saying just a word as to the modern trend in the feeding of infants on the part of the best pediatricians. Whereas there was a time not so very far back when doctor vied with doctor in the creation of milk formulas that exhausted the resources of the higher mathematics to comprehend, much less to prepare, there has of recent years been a most healthy reaction in the direction of what has come to be known as "simple dilutions." Hand in hand with this simplification of what is done with milk *after* it comes to our hands, or perhaps lagging a step or two behind, has come a realization that perhaps it is even more important to know and to control what happens to this highly perishable and most easily contaminated product *before* ever it comes into the diet kitchen at all. In other words, whereas it may be beyond dispute that "pigs is pigs," it



certainly is not equally true that "milk is milk," at least in our vast metropolitan areas today, if by "milk" we mean a food that is clean and decent enough for our babies. It must come to be realized on a far greater scale than has so far been the case, that the only milk fit to be given to an infant or a child, inside the hospital or out, is pure, fresh, unaltered, uncontaminated, sweet-smelling and sweet-tasting cow's milk; and quite as important is it to realize, I say it advisedly, that the only milk that conforms to these simple and minimum requirements, in these huge cities of ours today, is certified milk. I would urge you as dietitians, who would be amazed and scandalized if you were asked to prepare for your patients tainted meat, cold storage poultry, third class eggs, or dirty or wormy cereals, to take equally high ground, on any and all occasions when the opportunity comes to you, with regard to the milk that you are asked to modify for the little ones who look to you for the means of subsistence, and to urge upon your superintendents the desirability of procuring certified milk for the children's diet kitchen.

### NEWS ITEMS

Miss Ruby Odell has recently gone to Rochester General Hospital as dietitian. Miss Odell has been at the Corning Hospital, Corning, N. Y. since graduating at Cornell in 1921.

Miss Mary Louise Shaw is at St. Mark's Hospital, New York, N. Y., in charge of the diet kitchen and teaching of dietetics.

Miss Irene Willson gave up her work at Akron City Hospital to go with Mr. H. G. Yearick to the Homeopathic Hospital, Pittsburgh, Pa. Miss Willson was secretary of the Ohio State Association of Dietitians. Miss Mayme Lewis succeeds Miss Willson at Akron City Hospital.

Other dietitians who have recently assumed charge of departments in new places are:

Miss Nell Dahl in the Fairview Hospital, Minneapolis.

Miss Helen Clarke in the University Hospital, Columbus, Ohio.

Miss Margaret Anderson in the Trumbull Hospital, Brookline, Mass.

### COMBATting THE LOUSE IN TYPHUS HOSPITALS

The humble louse, the annoying activities of which have been directly responsible for millions of cases of typhus and thousands of deaths in post-war Europe, is the subject of an interesting report just issued by American Red Cross headquarters in Paris. The report describes the anti-typhus work done by the Red Cross during a very severe epidemic of typhus at Cattaro, Dalmatia, resulting in nearly 40 per. cent of deaths among Russian refugee patients there. The Red Cross sent a special corps of typhus specialists to the scene, under Dr. C. C. Yount of Pittsburgh and Dr. J. R. Ransom of Cleburne, Texas, and the epidemic was finally stamped out.

An interesting part of Dr. Ransom's report is devoted to describing the precautions taken to protect doctors and nurses engaged in the anti-typhus work.

"Protection of the personnel in the hospitals depends mainly on the efficiency of the disinfecting squad," writes Dr. Ransom. "Typhus is not directly infectious, it can only be carried by the medium of the louse. Therefore if patients are properly disinfected there is absolutely no danger to the hospital personnel. In this respect typhus

is similar to malaria. There is no danger from a patient with malaria, nor is there any danger from typhus.

"At our stations in Milina, on Cattaro Bay, every refugee was put through a delouser. All the hair was clipped close, and the patient was scrubbed thoroughly with soap and hot running water. The body was anointed with kerosene or coal-oil. Clean pajamas were placed on the patient and he was wrapped in a clean blanket and transferred to his bed in the hospital. His clothes were put through a pressure steam sterilizer, and furs were put through a sulphur bath. In this way only louse-free patients arrived at the hospital.

"Any person finding a louse on a patient or on the clothing of the personnel was required to report this immediately to the physician in charge of the hospital or to the chief nurse, at which time special steps were taken to discover from what source the louse came.

"It is seldom necessary for physicians or nurses to expose themselves by handling louse-infected patients and articles of clothing, as there are always present persons who have had typhus, who can handle typhus patients and their clothing. The work of the physician and the nurse should be directing and not handling patients or articles of clothing. Too many overenthusiastic persons think they must demonstrate the fact that they are not afraid of typhus or of work. These people are penny wise and pound foolish. They are sure to be infected sooner or later and then their work must be done by someone else.

"In the field, where physicians and nurses are required to come in close contact with infected cases, it is important that they be provided with a combination undersuit of closely woven white cotton, with stockings, long sleeves and a high collar. This garment should be worn just over the underclothing. Rubber boots or high laced boots must be worn to prevent louse from crawling up from the floor.

"Woolens should be avoided, as the louse clings to such garments. Cotton and silk are best. I prefer a trenchcoat as an outer garment. The material is of such texture that the louse cannot cling to it and is easily shaken off.

"At the completion of the day's work the outer garment should be taken off, shaken and hung up where it will not come in contact with other articles of clothing. A bath should be taken every night and all the clothing changed. To finish the bath the body should be sponged with a soapy water made of germicidal soap which should not be washed off. I have been using this soap ever since I began to work in typhus areas; and as I have caught several lice on my body and have never been bitten by one, I am convinced that the louse will not bite the skin recently washed with such a soap.

"One thing that must be remembered is that typhus is not as frequently conveyed by the bite of the louse as it is from the crushing of the louse and smearing of the body contents over the abraded skin. The natural instinct when one feels a bite is to scratch or rub the area through the clothes. This is just what must not be done, because this crushes the louse and smears its body contents. In Milina we carried a bottle of chloroform, and when we suspected the presence of a louse on the body or we felt a nibble, we simply covered the spot with the open mouth of the bottle and inverted it so as to saturate the clothes over the area with chloroform. In this way the louse, if present, was killed and we avoided the danger involved in crushing by scratching or rubbing. Not only does the chloroform kill the louse, but it neutralizes the virus in the bite."

## HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director  
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### TWO CINCINNATI HOSPITALS ARE CHAMPIONS OF ELECTRIC COOKING

By WALTER T. WILLIAMS, CINCINNATI, OHIO.

JUDGING from the experience of two hospitals in Cincinnati, the use of large electric ranges and ovens is altogether satisfactory and offers many advantages. In the kitchen of the Deaconess Hospital, of which institution Rev. A. G. Lohmann is superintendent, all of the cooking is done on a large electric range, which has as an adjunct a large electric steam table or warmer. Both of these units are shown by accompanying illustrations. At the time of this writing they have been in use about six months, and therefore it may be stated that they have had a thorough and practical test.

The range is of the Edison heavy-duty type, with four enclosed surface, or top, units and two oven units. When the current is turned on to full capacity, four kilowatts per hour are used by each of the former and three kilowatts per hour are used by the latter, making the total consumption when all units are turned on, twenty-two kilowatts per hour.

The actual current consumption of the range, however, is much less than this, for the maximum current consumption is only used for a short time when the preparation of a meal is begun. As the stove and the food heat up, the amount of current used is gradually reduced. For instance, as soon as the contents of a vessel reaches the boiling point, the switch controlling the unit on which it stands is brought back to "medium" and later to "low," which maintains a sufficiently high temperature.

In case of an oven, whether it is a part of the range or a separate one, the economy is still greater. This is because the oven, like a "fireless cooker," is so well insulated against radiation that the heat cannot escape, and when it and its contents become heated to the desired temperature the electricity may be turned off and the cooking will continue for a long time.

Each of the six heating units of the range is controlled by a three-heat switch, and this affords a diversified temperature, making each unit independent of the others. These stops are respectively marked "High," "Medium" and "Low." At medium heat the current consumption is one-half and at low heat it is one-fourth.

The electric steam table is not needed at all times, but it has been found to be very useful when an unusual number of persons are to be served, on such occasions as meetings of the board, meetings of committees, and entertainment of large numbers of guests on special occasions. The maximum current demand of the steam table is small,

it having two units of three kilowatt consumption each, or six kilowatts in all.

The combined current consumption of the range and the steam table, as determined by a survey by a careful and reliable electrical engineer and as checked up by an expert of the power company, averages 4,000 kilowatts per month. While under local conditions this current cost is about \$13 more per month than the fuel cost of the gas range which formerly was used, this excess of cost is more than offset by other matters. For one thing, the shrinkage of

meats that are prepared in the oven is greatly reduced, and while no exact figures are available, it seems that this alone should throw the balance in favor of the electric range. With other fuels the shrinkage of meats cooked in an oven has been found to be 30 per cent, but with an electric oven the shrinkage is only 13 per cent, leaving a saving of 17 per cent in favor of the electric device.

The floor space occupied by the electric range is only 39 by 48 inches, while a gas or coal range of the same capacity usually takes up considerably more room. On the top of the electric range there are no lids and openings, as



This electric range used in the Deaconess Hospital, Cincinnati, for several months has given general satisfaction and is regarded as economical.



is the case with gas and coal ranges, but the vessels are set on the top over the heating units. For this reason the cooking utensils are never blackened with soot; there is no flame to touch them. This feature also effects a saving, for it reduces the kitchen labor; with a gas or coal range it takes more than a little time to remove the soot and coal-tar deposits with which the flame coats the bottom of each vessel. While this economy cannot be demonstrated in dollars and cents, it nevertheless is self-apparent.

The hospital's chef is very enthusiastic about his electric range for several reasons. With the gas range he could not maintain an even temperature, for the pressure of the gas was not regular. Sometimes, in cold weather, the gas supply reached the vanishing point, as natural gas, the only kind available, has a way of doing. With the electric range the chef is able to maintain an absolutely even temperature, at any necessary degree and for any length of time, which to him is a very important thing. Being well insulated isothermally, the range gives off a minimum amount of heat, which adds to the comfort of the kitchen.

The Deaconess Hospital has accommodations for eighty patients and there are forty-five nurses and eighteen miscellaneous employees, so when it is filled there are about 143 persons to be provided for. The range easily takes care of the cooking for all, and with the assistance of the steam table a much larger number can be taken care of without trouble. In fact, I was assured that the outfit easily could prepare three meals a day for eight hundred persons, and that this would require but a small amount of additional current.

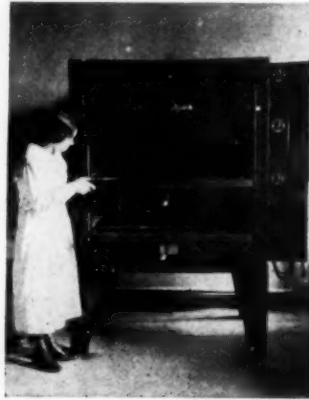
#### Electric Oven Costs Hospital Nothing

The electric bake oven seems to be an entirely satisfactory and extremely economical apparatus. One of the illustrations herewith shows a large portable electric bake oven. This is located in another hospital in Cincinnati, the Good Samaritan, of which Sister Rose Alexius is superintendent. This large oven takes care of all of the miscellaneous baking, such as rolls and pastry, of this large hospital, which has beds for 218 patients and a resident personnel of 185 persons, making 403 to provide for when the institution is filled.

It literally costs nothing to supply the current to this oven. On the contrary, the hospital reduced its total expense for electricity when it installed the oven, thereby getting a revenue from it. The current used by the hospital now costs about \$7 per month less than it cost

before the range was installed, because by increasing its electric consumption the institution earned a decreased rate per kilowatt, so now it gets a greater amount of electricity than before for a decreased amount of money.

This oven occupies a floor space of 45 by 36 inches, the latter dimension being from front to back, and it is 70



An electric bake oven is used in the Good Samaritan Hospital of Cincinnati. The institution's total bill for electricity was less after the oven was installed than it was before it was put in.

inches high. It is in one section, with three baking compartments, each 8 inches high, 27 inches deep and 38 inches wide, with a heating unit under each and a fourth unit over the top compartment. The maximum current consumption is nine kilowatts. Each of the four units has a three-heat control, with "Full," "Medium" and "Low" indicated, the same as on the range.

Each compartment has a thermostatic thermometer at its side, next to the heat control, and this gives a true reading of the temperature within,

thereby taking all guess-work out of the baking operation. As soon as the baker has ascertained the temperature which is necessary for a given article he can so regulate his oven as to be sure that his product always will be the same, as far as the baking is concerned.

An electric oven, if properly constructed, has a very low current consumption. As soon as the oven and its contents reach the necessary temperature the current may be reduced, or it may in many cases be turned off altogether. This is because the oven is well insulated isothermally; as practically no heat is lost through radiation, it becomes a "fireless cooker" and baking continues for a long period, from stored heat.

The foregoing brings up some important matters that should be considered in connection with the installation of electric cooking apparatus. In almost every city there is a sliding scale which automatically reduces the price per kilowatt of electricity as the consumption of current increases. When the Deaconess Hospital installed its electric range and steam table, its increased consumption of electricity automatically brought the rate from six cents per kilowatt down to three and one-third cents per kilowatt. Likewise, as has been explained, the current rate was reduced to the Good Samaritan Hospital, and the result was that after it had installed its electric bake oven the institution's electric bill was less than before.

Gas, it should be remembered, varies as to heat units. Natural gas, which is the only kind supplied in Cincinnati, has many more heat units per thousand cubic feet than are apt to be found in the manufactured gas which is supplied in most cities. Besides this, one natural gas may contain more heat units than another. Hence, in making calculations as to the comparative cost of gas and electricity one should consider the cost of gas by heat units, not merely as to thousands of cubic feet.

#### Some Advantages of Electric Cooking

Some of the advantages offered by the use of electric cooking apparatus may be summarized as follows: The danger of burning or scorching is negligible—one might almost say absent. The fire risk is reduced, for there is



The electric steam table used in the Deaconess Hospital, Cincinnati, is an adjunct to the electric range. It has been found to be most convenient and its current consumption is very small.

no danger of a gas explosion and no matches are used. No unsightly piping is necessary to carry off the gases and fumes, and there is no necessity of cleaning pipes in which soot has collected. An even temperature may be maintained indefinitely and in case of an oven there is no danger of spoiling the result by opening the door. There is very little radiation from an electric range and there is none whatever from an electric oven.

Other advantages depend on the cooking equipment of the hospital and its requirements. For instance, the Good Samaritan Hospital has no electric range, but some of the baking which ordinarily would be done in the oven of a range is done in its electric bake oven. This includes the baking of chickens, potatoes and many

other things; even rice is cooked in the electric bake oven.

The heating elements for the surface units of the range last several thousand hours, are not expensive to renew and may be replaced in five minutes. The heating units for both types of ovens are so constructed as to last indefinitely. There are no stove lids to warp, no gas burners to adjust and clean and no linings and small parts to replace at intervals.

It may be well to state in conclusion, for the benefit of any who may want to make comparisons, that from a competitive fuel-cost standpoint, conditions here are much less favorable to electric cooking than they are in most other cities. Local conditions should be considered in all calculations.

## NEW SALINE APPARATUS MEETS REQUIREMENTS

By A. B. DENISON, M.D., ASSISTANT DIRECTOR, LAKESIDE HOSPITAL, CLEVELAND, OHIO.

IT IS altogether probable that the production of normal saline solution is a problem that faces most hospitals, particularly those with larger surgical services. The methods most commonly used in making saline are certainly far from satisfactory in many respects. They are mostly slow and very inaccurate and offer a maximum of opportunity for contamination of the saline. In this hospital the problem reached such a magnitude that we were forced to devise a method whereby we could make better, more accurate, and more uniform saline in a shorter period of time. In so doing we kept in mind the general basic requirements of a satisfactory salt solution for subcutaneous or intravenous use. These requirements are:

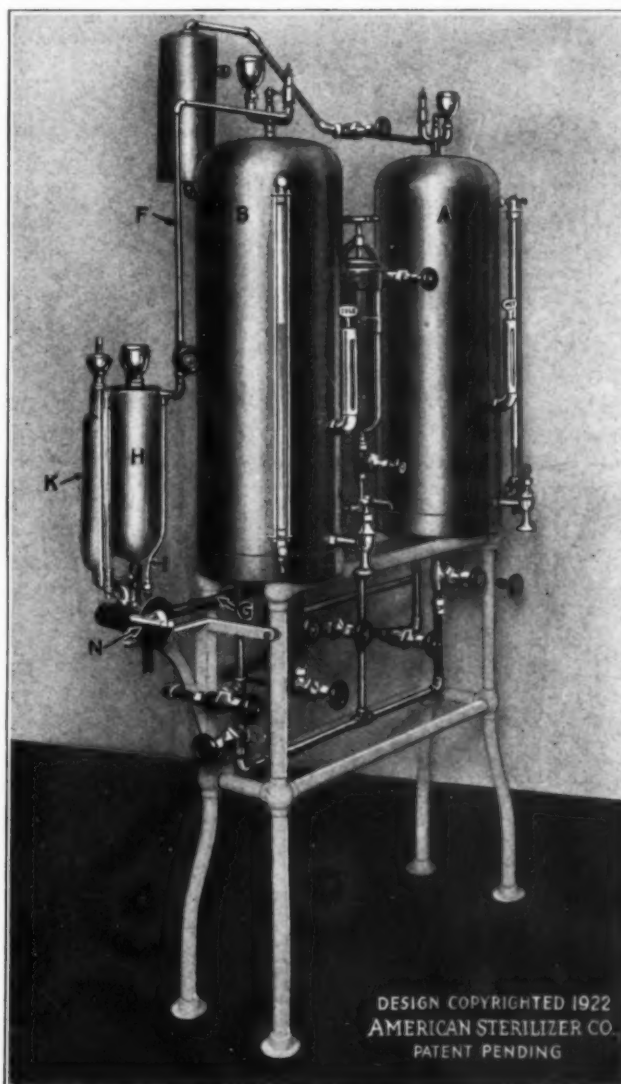
1. Sterility. It must be absolutely sterile.
2. Freedom from sediment or cloudiness.
3. Freedom from any element other than those intended, viz: salt and water.
4. Uniformity. Every flask of saline must be of exactly the same concentration and this concentration must be fixed and known.

The attachment we have developed meets all of these requirements perfectly and at the same time shortens the time required most strikingly. The speed of this process is particularly striking when compared with the fractional sterilization method so commonly in use.

In discussing the apparatus it may be well first to refer to the illustration showing its construction. It is seen first that the apparatus is an attachment to be added to any ordinary

water sterilizer with very little alteration. The condenser is so arranged as to deliver the water distilled from the first tank ("A" boiler) to the second distilled water tank, "B." A steam by-pass "F" is taken from the upper part of the distilled water tank to provide for sterilizing the saline attachment.

The saline apparatus consists of three main parts: the measuring valve, the saline storage tank and the mixing chamber. The measuring valve is graduated to hold exactly 80cc of liquid at room temperature. It is provided with ports so arranged in its circumference that in the various positions as indicated by the dial "N," the proper ports are open to carry out the various steps of the operation. At "close" all are closed. At "salt" the ports leading to the tank "H" and the air release pipe "I" only, are open. Since the pipe "I" is lead from the highest part of the measuring valve, there is no air pocket formed and the measuring valve is completely filled with the salt solution from the saline storage tank "H." So, when the measuring valve is turned so as to close these ports, exactly 80cc of the strong salt solution has been "bitten off." When the indicator is moved around to "mix," ports are brought open opposite the pipe "G" leading from the distilled water storage and opposite the pipe leading to the mixing chamber "K." Distilled water then flows



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PATENT PENDING

Diagram of Saline Apparatus



from the large tank through the measuring valve until the mixing chamber is full. A float valve prevents overflow. This mixing chamber has a capacity of exactly 920cc, making the total volume of this chamber and the measuring valve exactly 1000cc.

When the indicator is turned still further around to "draw off" all ports are closed except the ones opposite the mixing chamber and the outlet. The mixing chamber and the measuring valve are thus completely drained, delivering exactly 1000cc of saline. The concentration of the resulting salt solution naturally is dependent upon the concentration of the strong salt solution in the saline storage tank, "H." If this strong solution is 10 per cent the resultant saline solution will be 0.8 per cent. So, if it is desired to make a solution of a concentration different from 0.8 per cent the strong salt solution must be correspondingly changed from 10 per cent.

Of course it is realized that the description of this piece of apparatus is very fragmentary and sketchy and omits many essential details but it is hoped that it may serve to give a general idea of how the apparatus is made and how it works. We have found it extremely satisfactory in every way. The distilling apparatus works very rapidly and efficiently and after the distilled water is collected, the saline can be made very rapidly indeed; in fact it requires about nineteen seconds to carry

out a complete cycle of measuring the strong salt, measuring the distilled water, mixing and drawing off the one liter of saline solution.

We have shown by repeated experiment that the saline solution is perfectly sterile, thus proving the possibility of dispensing with the old time-consuming method of fractional sterilization. The saline solution is perfectly clear and free from sediment or cloudiness. Repeated analyses have failed to show any contamination from any source.

No filtering of the solution is needed, thus removing another possible source of material contamination. Further, the saline produced is uniform in concentration, every sample taken being practically the same. The apparatus is practically foolproof and reduces greatly the points where error may creep in.

It is perfectly obvious that the possibility of variation of concentration is greatly reduced since it is necessary to make up accurately but one solution instead of attempting to measure each individual flask of saline accurately. This apparatus is so built that once the strong solution is accurately made up, all saline from this solution will be the same in concentration. The fact that the apparatus is a closed system preventing contamination insures the absolute sterility of the final solution.

The apparatus was on exhibit at the convention of the American Hospital Association in September.

## THE ROTHROCK DELIVERY BED

By K. H. VAN NORMAN, M.D., SUPERINTENDENT, THE CHARLES T. MILLER HOSPITAL, INC., ST. PAUL, MINN.

**D**R. J. L. Rothrock, in charge of the obstetrical and gynecological services of the Miller Hospital, St. Paul, has devised and recently has had manufactured a delivery bed which incorporates so many long felt wants that it seems desirable to present its advantages to the hospital world.

The chief objective sought in working out this design was to produce a practical delivery bed which would be comfortable for the patient, simple in construction, easy of manipulation and on which the position of the patient could be quickly changed to the usual positions desirable in normal or instrumental deliveries.

1. The bed is of very simple design and can be easily operated, with the patient upon it, by one person.

2. It offers unsurpassed facilities for the preparation of the patient with the minimum amount of soiling of linen.

3. The position of the patient recommended for normal delivery makes possible the carrying out of a more consistent aseptic technique than is possible with any hitherto devised plan of management. With the buttocks brought well down to

the lower end of the upper section and with the lower section of the bed slightly lowered, the discharges from the patient towards the close of the second stage of labor may be received in a basin and the field may thus be kept reasonably clean.

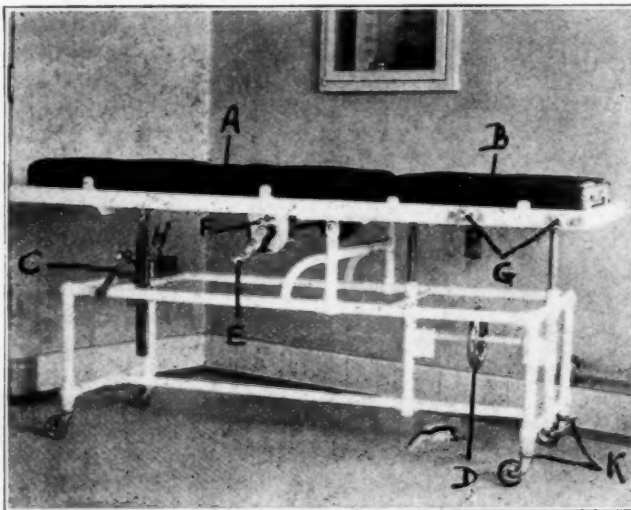
4. This position of the bed facilitates delivery of the shoulders after the head is born as it enables one to make traction downwards and backwards.

5. The lower section of the bed, when slightly lowered, affords a convenient platform on which the new born infant may be placed until the cord is tied and severed.

6. Furthermore, this position of the bed during the third stage of labor permits placing a basin under the patient to receive the blood and placenta, thus preventing the soiling of the bed.

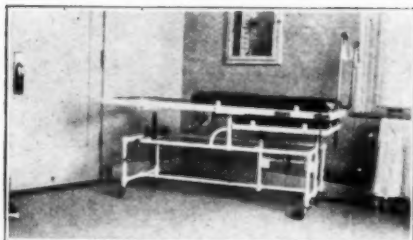
7. It also permits inspection of the perineum and facilitates the repair of lacerations without bringing the patient to the foot of the bed.

8. The foot-rests are of a new and original design with flexible joints adapting themselves to the comfort of the patient and the foot may be securely strapped on so that



The Rothrock table in ordinary position showing:

- a. Upper section.
- b. Lower section.
- c. Crank for raising or lowering head of bed.
- d. Wheel for lowering or raising lower section.
- e. Crank for rolling upper section to foot of bed (over lower section).
- f. "T" shaped lock for locking rolling gear.
- g. Sockets for foot rests.
- h. Tray for ether masks.
- i. Brakes on casters.



Upper section rolled down over lowered lower section.

changing the position of the patient on the bed.

The bed has the following dimensions:

Length over all, 74 inches; upper section, 42½ inches; lower section, 28½ inches.

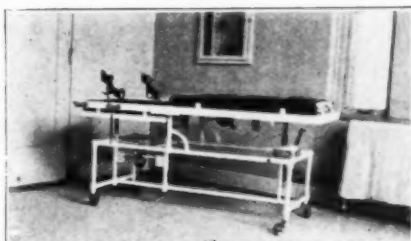
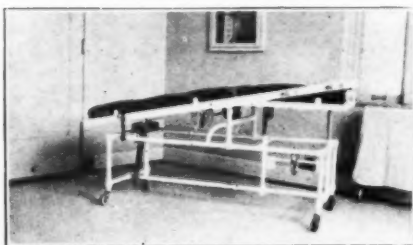
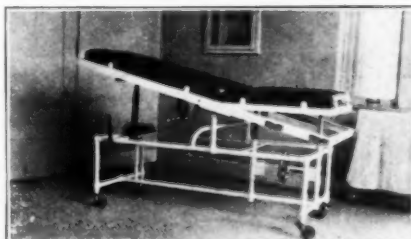


Table in position for reception of patient, with end section lowered.



Bed with head lowered.

been in use for the past three months and it came up to every expectation. It was manufactured by a well known firm of the Middle West.



Bed with head raised.

in anesthesia the patient cannot disengage her feet.

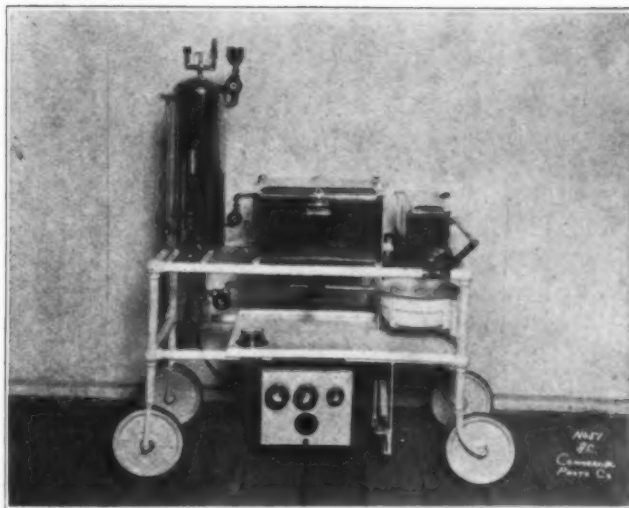
9. In case of post partum hemorrhage or sudden collapse, the head of the patient may be lowered without

Width—outside, 28 inches; inside, 26 inches.

Height—to top of frame, 32 inches; to top of cushion, 35 inches.

Cushion—3 inches thick.

The table has



Portable sterilizing and hot dressing outfit

The hot dressing container is fitted with a spray coil and a specially designed steam trap so arranged as to insure thorough saturation of the dressing with uniform distribution of heat throughout the chamber. The foot control raises and lowers the cover of this container, while a hand control regulates the cover and also raises the tray of the instrument sterilizer.

Additional equipment includes a swinging soiled bandage pan and an instrument receptacle located in the shelf of the frame.

The outfit is supplied with electric heaters fully submerged and connected with cords to multiple heat switches, provided with separate fuses for each switch. The water tank heater is the multiple unit type, and the heaters for the hot dressing container and instrument sterilizer are of the automatic cut-out type, thermostatically controlled.

As indicative of the care exercised in planning this outfit attention is called to the special bell-protected draw-off cock from the water container, the air filtering vacuum valve, and the thermometer indicating both temperature and pressure.

## HOSPITAL TRUSTEES AWARD TWO PRIZES IN WARREN TRIENNIAL

Because of the difficulty in determining the relative merits of two essays submitted for the Warren Triennial Prize of which the general executive committee of the Massachusetts General Hospital, Boston, is the arbitrator, two prizes were awarded this year.

At a meeting of the trustees of the Massachusetts General Hospital held October 13, it was decided that two prizes instead of one be awarded this year, the first prize to be \$500 and the second prize to be \$250; the award of the second prize this year, however, not to be taken as establishing a precedent.

There were twenty-one essays submitted, the contestants being from the following countries: Poland, Germany, Italy, Hungary, England and United States.

The first prize went to the essay, "The Circulation in the Mammalian Bone-Marrow," written by Cecil K. Drinker, M.D., Katherine M. Drinker, M.D., and Charles C. Lund, M.D., all of Boston.

A second prize was awarded to the essay, "The Effect of X-Rays on the Nuclear Division," written by James Mott Mvaor, M.D., Union College, Schenectady, New York.

## A PORTABLE ELECTRIC STERILIZING AND HOT DRESSING OUTFIT

One of the interesting innovations in hospital equipment which was introduced to the field at the Atlantic City conference of the American Hospital Association was a new portable electric sterilizing and dressing outfit.

The application of this equipment in the modern institution is readily apparent to an administrator. It permits of hot sterile dressings being applied at the bedside of the patient and gives a certainty of asepsis and a convenience that has hitherto been lacking.

The outfit is mounted on a substantial tubular steel frame finished in white enamel and supplied with four large rubber-tired wheels, two of which are swiveled.

Electric heating units are supplied for the various parts of the outfit and electric connections can be readily made in the ward or private room. The outfit consists of a four-gallon water sterilizer or reservoir, electrically heated; a hot dressing container 9" deep, 12" wide and 18" long, and an instrument sterilizer 5" deep, 6" wide and 16" long.



## ECONOMIES IN THE BOILER ROOM

THAT superintendent is indeed fortunate who does not find the problem of the boiler room and power house a more or less constant worry and anxiety. The fact that this is so frequently the case is due in some measure at least to a lack of definite knowledge of boiler room problems on the part of the average hospital executive. There is probably no other department of the hospital that requires more careful attention in order to prevent the constant accrual of undue waste and expense.

The same problems confront every hospital superintendent, no matter what the size of his institution or whether the so-called boiler room includes merely an ordinary heating plant or whether it is complicated by a range of steam boilers, electric generators and other power equipment. It is a recognized fact that each year thousands of dollars needlessly go up in smoke through the flues of the boiler room. A large part of this waste is preventable and simple precautions will mean a definite saving to the hospital.

### Fuel Economy Essential this Winter

While it is at all times necessary to exercise constant supervision of the boiler room in order to secure proper economies, it would appear as if such supervision would be particularly necessary the coming winter, not only because of the dollars and cents involved, but because of the probable necessity of fuel conservation on the part of all.

From present indications it may be difficult to secure ample fuel supplies. Under such conditions it is natural that unsatisfactory fuel will frequently have to be used. With these conditions confronting him, every hospital superintendent should take immediate steps to see that his boiler room and heating equipment are in such condition as to operate most efficiently, and to improve the operation of the boiler plant so as to secure the greatest possible economy and the necessary even temperature for the institution.

Many things can be done in every boiler room which will increase the efficiency of the installation. The majority of institutions now employ steam heat. Boilers for the generation of steam, as a rule, are divided into two classes: the water tube (in which the water is contained inside the tube and the gases from the furnace pass over the outside), and the horizontal return tubular boiler (in which the water surrounds the tube and the hot furnace gases are exposed to the shell of the boiler and also pass through these flues). Various methods must be employed with either type of boiler to secure proper economy.

In many institutions the boiler room and power plant have not received the proper attention in planning and the result is that they are not particularly desirable places in which to work. At the same time many hospital executives have been prone to consider any kind of labor good enough for the boiler room. As a result the ability to shovel coal is regarded as the main qualification of a fireman.

Ventilation, light, fresh air, lockers, and washing facilities for the men cost but little and go a long way toward raising the morale of the boiler room force. A clean, light, airy boiler room will attract good men, whereas a dirty, dark hole will attract no one who can get another job, so if a superintendent wants to build up the efficiency of the boiler plant, let him first provide decent working conditions for the men and an attractive wage. A fireman

can waste in one day in a power plant his entire month's wage.

### Physical Equipment of Boiler Room

This article, however, is planned to deal with the physical equipment rather than the personal element in the boiler room. The many sources of loss in the boiler plant may be enumerated in brief as follows:

*Dirt.*—Both inside and out on boiler tubes. An accumulation of scale on boiler shells and drums. These are indicated by a high flue gas temperature and also can be observed by the slightest inspection.

*Air leaks in boiler settings.*—Too much attention cannot be paid to cracks in boiler settings. As soon as one is noted, it should immediately be plastered up. There are many good makes of plastic compound carried on the market for sealing up boiler settings and maintaining them permanently tight.

*Ash pits.*—On stoker-fired boilers, the ash pits and doors must be as tight as the setting for, if not, air will leak in and cause a loss in efficiency. On hand-fired boilers, the ash pit doors should be removed as there is a tendency for the firemen to attempt to regulate the amount of steam by opening and closing these doors instead of using the damper provided in the up-take from the boiler. There is no quicker way of wasting a large amount of fuel.

*Baffle walls.*—In the water tube type of boiler, the flow of gases from the furnace to the breeching is directed by a series of baffles constructed of fireproof material. In removing tubes and in the normal use of the boiler, these baffles often become broken and leaky. Hence the gases "short circuit" and give a high temperature at the up-take of the boiler with a consequent loss in boiler efficiency.

*Bridge walls.*—On water tube boilers, the bridge wall should be carefully maintained, especially at the point where it comes in contact with the first directing baffle or pass. On hand-fired return tubular boilers it was formerly the practice to build the bridge wall up very close to the shell of the boiler on the theory that the flames would impinge on the boiler surface and give a much better evaporation. This theory has been completely discarded. It has been found that the relatively cold surface of the boiler so chills the gases that they will not re-ignite.

*Careless firing.*—This divides itself up into many different phases. With stoker-fired boilers the usual tendency of the firemen is to run several short fires on a three-boiler plant rather than two long full fires and to use the third boiler merely for regulating purposes. Owing to the nature of the chain grate stoker, a large amount of air enters the furnace from the uncovered portion of the grate causing a serious loss in efficiency. On hand-fired boilers, the one-shovel method of firing is the best, but the most difficult to really put into effect. The tendency of a fireman is to fill up a furnace and then sit down. This means the introduction of a large quantity of green fuel into the fire; heavy black smoke indicating that a large amount of unconsumed gases is passing into the stack as the result. The banking of boilers also comes under the head of careless firing. It is difficult to lay down any rule for banking. It is simply a case of getting the men interested in seeing just what is the minimum amount of coal with which they can bank a boiler. It is clearly a case of individual effort.

**Feed water temperatures.**—One of the most common losses in the boiler plant is the failure to maintain proper feed water temperatures. These temperatures can be kept up by keeping sufficient steam supplied to the feed water heater. At the same time the heater must be kept clean. For example, if feed water has been heated to 200 degrees F. each pound of water delivered to the boilers as received represents 200 B.T.U. more heat than if pumped into the boiler at the average temperature of 60 degrees F., assuming that the boiler pressure is 125 lbs. per sq. inch. The heat required to make a pound of steam from the original temperature of 60 degrees is 1164 B.T.U.; this represents a saving of 200 B.T.U. plus 1164, or 17 per cent. Thus the saving is directly reflected in a corresponding reduction in the coal consumed. An approximate rule is that 1 per cent of coal is saved for each 11 degree rise in the feed water temperature, provided this is accomplished by heat that otherwise would have been wasted.

### Common Causes of Fuel Loss

The following paragraphs outline various conditions that result in constant loss. In addition there are certain methods that can be applied to build up the efficiency of a heating and power system.

**Water tube boilers** should be provided with an accepted type of tube cleaner of a diameter that will just allow it to pass into the tube. If tube cleaners are employed that are too small, a large amount of scale is apt to remain in the tube.

In cleaning return tubular boilers, one of the many hammer cleaners should be provided; also some form of a steam jet soot blower. There are a number of efficient soot blowers on the market and these work out particularly well for water tube boilers. It is quite necessary, however, to see that employees use these blowers regularly (at least once a day), and that they are kept in proper repair.

A regular and careful inspection should be made of the ash pit and ash pit doors, and whenever a boiler is taken out of service, these pits should be thoroughly inspected.

**Dampers.**—For regulating the boiler, a damper in the uptake flue should be provided. Under no circumstances should firemen be permitted to regulate the steam by means of the ash pit doors.

**Baffle walls.**—These should be regularly inspected, using a strong high power electric light in the combustion chamber so that any leaks or cracks can be readily detected by the light shining through. High temperature cement should be applied for stopping these cracks and leaks.

**Feed water temperatures.**—In almost every hospital a large amount of steam is used for cooking, sterilizing and heating purposes. The steam in the engines of the electric plant, when such installations are used, is generally a small proportion of the total amount of steam generated by the boiler plant. It is of great importance, therefore, that these drips be so piped that all of this water is returned to a hotwell or surge tank at the boiler plant where it can be pumped into the feed water. This water contains a large amount of heat and is condensed steam, free from scale; raw water from wells or rivers is not.

### The Boiler Room Appliances

There are many devices on the market for producing economies in boiler room operation. The following named instruments, accepted commercially, are reliable and thoroughly practicable. They are named in the order of their importance:

**Recording pressure gauge.**

**Recording thermometers for feed water temperatures.**

**Draft gauges.**

The value of these appliances will be self evident to the farsighted executive, and he will appreciate the results obtained from their installation.

**Flow meters.**—For metering the amount of water going into the boilers. If further refinement is desired, the boiler flow meter can also be used. This gives an indication of horse power.

**Scales for weighing coal.**—With a water meter and with means for determining the weight of coal, the evaporation, which is the measure of efficiency of the boiler plant, can be readily determined from day to day.

**Automatic feed water regulators.**—Two devices are involved in feed water regulation: first, the automatic regulator for feeding water into the boiler as it is needed. To make this device operate satisfactorily, it is necessary to employ on the boiler feed pump, a device known as an excess pressure boiler feed line regulator. The function of this valve is to maintain a constant differential pressure between the steam pressure in the boiler and the water pressure in the feed lines, thereby maintaining a constant hydraulic head across the valve of the automatic regulator. Unless this is done, results with the automatic feed water regulator can be poorer than hand regulation.

**Damper regulators.**—The damper regulator is a successful operating device operated by steam pressure from the boiler, which opens and closes the damper in the uptake as the steam pressure in the boiler varies. This in turn is a measure of the demand upon boiler plants. There are many satisfactory forms of damper regulators.

In general it may be stated that stoker firing is applicable to plants of 200-horse power boilers and above. Below this the size of the stoker becomes so small that it is not economical and a good hand fireman can give better results than the stoker. Above 200-horse power, however, it is difficult to get men to handle boilers satisfactorily. Furthermore the automatic stoker is a means of reducing labor. Another fruitful source of labor waste around power plants is improperly designed coal and ash handling systems. Too much attention and consideration cannot be given to this problem.

### INFANT MORTALITY RATE FOR 1921 IS LOWEST ON RECORD

A record low infant death rate of 76 per 1,000 population is shown in the birth registration area of the United States for the year 1921.

The Department of Commerce will soon issue a bulletin, based on 1921 figures compiled by the Bureau of Census, showing for each state and each city in the birth registration area the number of births and the infant mortality rate, together with figures for 1920 for comparison.

These 1921 figures for a population of 70,425,705 show 1,714,261 births, 825,511 deaths at all ages, and 129,598 deaths under one year of age, which give a birth rate of 24.3 per 1,000 population, a record low death rate of 11.7 per 1,000 population, and a record low infant mortality rate of 76. In 1920 the rates for the birth registration area were: birth rate 23.7 per 1,000 population; death rate 13.1 per 1,000 population; and infant mortality rate 86.

For the state the lowest infant mortality rate (51) appears for Oregon, and the highest (98) for Delaware; for cities of 100,000 population or more the lowest infant mortality rate (50) appears for Portland, Oregon, and the highest (114) for Fall River, Mass.



## THE CARE OF PATIENTS' CLOTHES\*

By HAZEL A. GOFF, SUPERINTENDENT OF NURSES, BLODGETT MEMORIAL HOSPITAL, GRAND RAPIDS, MICH.

EVERY nurse has experienced misgivings in regard to the proper care of patients' clothes. Doubtless every executive in the administrative or nursing department of a hospital has spent some hours searching for mislaid patients' clothing or belongings.

Two main factors must always be considered regarding this subject:

1. The carelessness of individuals about their personal belongings, and; 2. The thoughtlessness of the average human being for the property of others.

We can never overcome the first consideration to any appreciable extent, but in the training of student nurses the second is a very vital problem. Its only solution is to establish a definite system of caring for patients' belongings and then adhere to that system. If the students have some part in working out the system they will slowly but surely learn to appreciate the value of other's property; it soon gets to be a habit and one of the good habits which they should form early in their training.

### Receiving Ward Makes Problem Simplest

As to the system to be adopted, it depends entirely upon the type of hospital and the facilities at hand. Large hospitals, where patients are admitted to a receiving ward, usually have the simplest arrangement. After preliminary observations have been made and the patient accepted, he is taken in charge by an attendant, male or female as the case may be. In the bathroom his clothes are removed, tied in a bundle, labelled and placed in a chute. After the bath the patient is equipped with hospital clothing and taken to the ward designated. The chute from the bathroom usually ends in a sterilizing room, where the clothing is disinfected, bundled, tagged and stored.

In other institutions, with similar admitting facilities, the nurse makes duplicate lists of clothing, valuables and all other articles. This list is signed by the patient and the nurse. One copy is retained with the clothes and the original given to the patient. Another arrangement is to retain the duplicate with the patient's chart and have the original filed in the office in case the duplicate is lost. This same procedure is commonly followed where there is no receiving ward and the clothes are kept in lockers near the ward. Again, it is varied in that the clothes are simply listed in a book kept for that purpose, signed by the patient and the nurse and then placed in locker or clothes room. This is a less sure and safe way, but even so, is more of a protection to the patient than when he is allowed to look after his own things, which is the procedure frequently followed on private floors.

The advantages of a central receiving ward are several. One nurse can care for the clothes of many admissions in less time and with less confusion, as there is usually more room in which to work and less danger of clothes being mixed, for here, listing the clothes will not be sandwiched in between numerous other duties.

### Tagging Clothes for Identification

On wards where the nurses are required to spend considerable time tagging and listing clothes, the question arises as to the value of time during a nurse's training spent in this way. There is no question but that this work

can be done by an attendant as efficiently and there is no question about it not being a nursing procedure. Nevertheless, does it not teach three of the vital principles we are making every possible effort to "put across" to our nurses today? These are: respect for the property of others, promotion of accuracy and development of system. Following the natural order of things, one should be opposed to this method. The writer lived through three years of the most elaborate tagging and listing which caused her to make many silent vows on the subject. According to the more modern idea of training possibly the students were exploited a little in getting the work done in that manner, but all have been repaid many times in the valuable lesson they learned—that is to "have a care."

Different methods of tagging the clothes are used. Some fold all the clothes, do them up in a half sheet or clothes square and fasten the name and ward on the outside of the bundle. The disadvantage of this plan is that the bundle must be tied very firmly or some articles may fall out; in that case the clothes become badly crushed unless most carefully folded.

Another plan is to tag with name and ward all the outer garments, place hats in paper bags, wrap shoes and rubbers together, put underclothing in a bundle, tag it and list contents on other side of the tag. The outer garments can then be hung up so as not to become wrinkled.

The types of clothes' lists used vary with the management of the hospital. Some use a card system (Presbyterian Hospital, New York), others have a more elaborate form where clothes received after admission or clothes given to the patient during convalescence are noted (University of Michigan Hospital). For general use the form suggested by the committee on forms and records of the American Hospital Association is good excepting that it might better contain a space for extra articles to be recorded. Listing patients' clothes in a book is neither business-like nor efficient. It takes more time to make the list; the ward, date, or locker number are often overlooked and the book may be mislaid at the time it is most needed. It is in these details that nurses are most apt to be lax or thoughtless.

### Lockers Should Be Well Ventilated

After listing patients' clothes the next consideration is storing them. Some hospitals have a central clothes room equipped with lockers, others have a room near the ward for this purpose. The only disadvantage of a central clothes room is the time spent running to and from the locker room which is usually in the basement or some other remote part of the hospital. The disadvantage of having lockers near the wards is that it is almost impossible to keep patients away from them. Some articles are given to convalescent cases and then difficulties follow. Locker rooms are seldom properly ventilated and frequently lockers are only half large enough.

In "The Organization, Construction and Management of Hospitals" by Dr. A. J. Oschsner and M. L. Strum lockers are described as follows:

"The only locker worthy of consideration in any hospital, be it a fireproof or non-fireproof building, is an all metal one, whether this be of the open type—namely, the wire mesh type, or the closed type."

\*Read before Institute of Michigan State League of Nursing Education, Ann Arbor, Mich., June, 1922.

All of these have their advantages, as they are built with a view of ventilation and sanitary conditions. The closed type form of metal locker, known as the "knock down" type is probably the best on the market today, inasmuch as it can be taken apart in a few moments, thoroughly cleaned and renovated, and put together in the same space of time. These lockers are made with the enamel burned on, which with ordinary care, should last for many years.

"Built in" lockers are particularly to be condemned, as there are few instances where they do not become unsanitary, even with the best of care. They cannot be constructed by the ordinary carpenter in such a manner as to be irremovable and sanitary at the same time.

It is wrong to suppose that a locker room is one that can be used for no other purpose because it is dark and out of the way. It is as necessary to have sunlight and ventilation in this as in any other room in the building; in fact, it cannot be too strongly advocated that this be the rule rather than the exception.

#### Opinions Differ as to Closets

Clothes closets have been discussed in *THE MODERN HOSPITAL* by J. A. Hornsby and R. E. Schmidt. They state in part, "The question of having a private clothes closet or not to have one has been much discussed. Some hospital boards believe closets sanitary and that no good private room should be without them. Again other hospital boards refuse to have closets and maintain that a patient should come to the hospital with only one change of clothing and that these should be kept in metal lockers in general locker room and returned to the patient when required.

The closet adds a number of additional corners and surfaces which increase the labor of cleaning but there should be no danger if it is maintained in a sanitary condition. Inasmuch as but little clothing need be stored in them it is best to build a false ceiling immediately above the door, cutting off a number of feet of useless space which is difficult to clean, an unnecessary first cost and an unnecessary cost of maintenance."

Another plan for a clothes room is to have compartments built in "box fashion" in which to place the bundles of clothes and keep the room locked. The disadvantages of this scheme are that the clothes are crushed and such a room is seldom properly ventilated. The top compartments have to be reached with a ladder so it is difficult to locate the proper set of clothes readily.

In private rooms there is a different problem. In the first place most all private rooms are equipped with a closet and a dresser where the patient may keep his belongings. With this type of patient you find friends and relatives are constantly bringing things to him and taking things home and they feel most indignant if it is suggested that the articles be listed. However the writer feels strongly that they should sign duplicate clothes slips, stating that they wish to retain these things at their own risk. Then when articles are mislaid they do not have the same critical manner toward the hospital.

#### Valuables Must Go to Safe

There is no question about money and valuables—they should always be put in the safe immediately upon entrance. We have made quite a point of this. A framed sign is on the admitting desk and beside each elevator stating a few of the essentials, one of them being as follows:

"The hospital maintains a depository for all valuables, and patients upon admission should turn over to the admitting officer all

moneys and valuables for deposit. The hospital will not be responsible for any valuables unless they are sent to the office and a receipt obtained."

This same statement is made under "Information for Patients" on the admission card which is given the patient in the doctor's office. There cards are placed under the glass on every dresser in the private rooms and every bedside table in the wards, so patients may read them. An envelope giving name, ward, date, valuables, name of patient and nurse, such as the one suggested by the American Hospital Association, is the most satisfactory way of filing valuables in the safe. Every effort should be made by the admitting office to care for these before the patient is sent to his room.

At Blodgett Memorial Hospital we have been extremely fortunate in the matter of lost clothing. Most of our difficulty has been with patients leaving things when they go home and these are usually patients who have special nurses. This is another argument for having the student nurses do a certain amount of the so-called "drudgery." They then remember some of these details after they graduate, and are more acceptable for hospital cases, thereby.

We have all articles which have been left behind sent to the training school office, tagged with the patient's name and room number. It would seem almost desirable for hospitals to have signs on the doors as they have in many hotels—"Stop! Have you forgotten anything?" At regular intervals the unclaimed accumulation of worldly goods is sorted over, cards sent to those who have left anything of value, requesting that they call or send postage for same. Then if the articles still are unclaimed they are turned into the linen room to which we occasionally apply for odd garments for charity cases.

#### Sense of Humor Is Essential

This is one place where it is well to have a sense of humor. For example, it took several telephone conversations, a couple of letters and an interview with six nurses to convince the widow of a very wealthy man that we had not appropriated two cotton handkerchiefs which she claimed her husband had with him when he entered. Compare this with a winter coat having a fur collar which a maternity patient has still not claimed, a pair of silver backed military brushes, a hair switch and two sets of teeth with ten gold crowns that we have in the office at present. Then again, someone will make a great effort and come a long distance to claim a worn-out pair of bedroom slippers. From our viewpoint, however, articles which do not belong personally to us must be considered valuable.

Some conclusions to be drawn from this article are:

1. That definite system to protect the hospital is most essential in the care of patient's clothes.
2. That the system may be very simple but should meet with the demands of the particular institution.
3. That any system in a training school needs constant supervision to make it work. Automatic ones have not yet been invented.
4. That student nurses need a certain amount of this training to make them value the property of others, and to teach them accuracy, neatness and order.

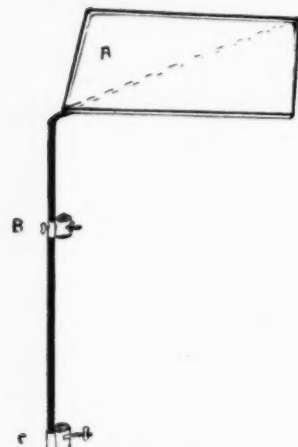
In a drop of river water or a speck of road dust the microscope reveals to us life in myriad forms, each distinct, but sharing in the one great principle which animates all living things. Every one of these infinitesimal creatures fills a niche of its own in the universe.—Robert W. Mackenna.



### A WARD DRESSING TABLE

By J. H. WOOLSEY, M.D., Instructor in Surgery, University of California Medical School, San Francisco.

An easily portable ward dressing table has proved to be indispensable in performing bedside dressings. The patient's bedside table is invariably overladen and it is poor technique to lay out a sterile field upon a patient's bed.



Ward dressing table adapted from so-called "adjustable instrument table" for use on ward surgical dressing-carriage.

ber to fit upon a corner post of the dressing carriage and a tunnel with a set screw through which

Because of this I adapted a table, for our use at the University of California Hospital, from the "adjustable instrument table" employed in the operating room and sometimes known as the "Mayo table."

This table consists of (A) a removable enameled tray seated in a horizontal frame to the corner of which an upright supporting rod is attached. The upright rod is in turn attached to the dressing carriage by two clamps, (B) and (C). Clamp (B) consists of a metal appliance lined with rubber

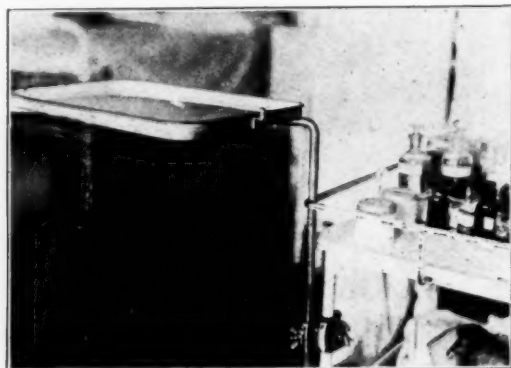
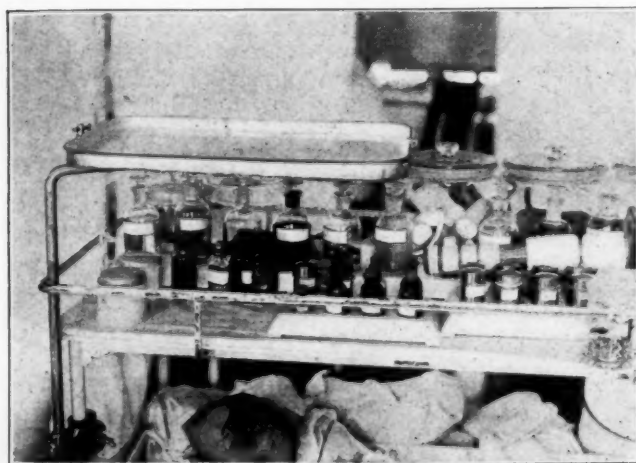


Table placed ready for use.

the upright of the dressing table may pass. Clamp (C) consists of a similar metal appliance to attach to the



Ward dressing table when not in use.

dressing carriage but with an opening only for one-half of its depth in which the dressing table upright may turn. Clamp (B) by the set screw holds the dressing table at any position desired, as when not in use, over the carriage. Clamp (C) regulates the height of the dressing table.

Such a table as this can be placed at the side of a bed, over a bed or at any point desired and yet when not in use may be placed over the carriage and so out of the way; it eliminates the delay of the nurse in finding a permanent level spot for the sterile field and leads to better technique in ward dressings.

### HOSPITALS NOTE DECREASE IN INDUSTRIAL ACCIDENT CASES

Industrial hospitals or institutions which receive injury and accident cases from milling centers must have noted the sharp decline in the number of such patients during the past year. A recent report of the U. S. Bureau of Mines shows that in 1921 there were only one-half as many accidents in mills and smelters, excluding iron blast furnaces, as in preceding year. Some figures on industrial accidents recently released by the U. S. Bureau of Mines follow:

Accidents at all mills and smelters, excluding iron blast furnaces, operated in the United States in 1921 resulted in the death of 27 employees and the injury of 4,494, according to reports received from operating companies by the federal Bureau of Mines. In the preceding year, 61 employees were killed and 8,863 were injured.

At milling plants, 10,047 men were employed, of whom four were killed and 1,214 were injured, as compared with 21 killed and 2,624 injured during 1920. The fatality rate in 1921 was 0.50 and the injury rate was 151.05 per thousand employees, based upon a standard of 300 work days per year, as against rates of 1.31 killed and 164.24 injured the year before. The total working time was 2,411,148 shifts, and represents an average of 240 days per man. The number of men employed represents a reduction of 37 per cent.

At the smelters 18,656 men worked 5,733,969 shifts, an average of 307 days per man, as compared with 24,944 men, 8,741,116 shifts, and 350 days per man in 1920. Fourteen men were killed by accidents and 2,129 were injured, or 0.73 killed and 111.39 injured per thousand 300-day workers. The corresponding rates in 1920 were 0.69 killed and 142.33 injured.

At the outside or auxiliary plants operated in connection with the mills and smelters, nine fatalities and 1,151 injuries occurred among 8,762 employees. The fatality rate per thousand 300-day workers was 1.08 and the injury rate was 138.54, as compared with rates of 1.11 killed and 116.19 injured in 1920.

Of the 1,214 persons injured at mills, 132 were hurt by falling, 130 by machinery, 108 by hand tools, 99 by falling objects, 73 by falling pieces of rock from sledging or crushing, 70 by crushers, rolls, or stamps, 70 by haulage equipment, and 64 by nails and splinters.

Of the 2,129 injuries at smelters, 401 were caused by burns from matte or molten metal, 287 by flying or falling objects, 179 by hand tools, 149 by haulage equipment, 146 by falls of persons, and 96 by machinery.

Of the 1,151 injuries to employees at auxiliary plants, 174 were caused by falling objects, 140 by hand tools, 125 by falls of persons, 90 by machinery, 78 by haulage equipment, and 70 by nails and splinters.

Answer a fool according to his folly.—Proverbs.

## OCCUPATIONAL THERAPY AND REHABILITATION

*Conducted by* HERBERT J. HALL, M.D., President, American Occupational Therapy Association,  
Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS,  
Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.  
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### OCCUPATIONAL THERAPY AT SOUTHEASTERN INDIANA HOSPITAL FOR THE INSANE

BY HAZEL IRENE HANSFORD, PH.D., SOUTHEASTERN INDIANA HOSPITAL, MADISON, IND.

**I**N JANUARY, 1922 an occupational therapy department was established at the Southeastern Indiana Hospital for the Insane at Madison, Indiana. The work was placed in charge of Mrs. Russel Doyne and she was given two girls, one of whom was to direct the work in the industrial room and the other one to help with the ward classes. Later another girl was added to the force.

Habit formation classes were held twice and three times each week in three wards on the female side. As

burlap and raffia were used as a medium for training. The most deteriorated cases often could do no more than ravel burlap. Some of these became quite proficient in this simple task and later were given more complicated tasks such as tying the burlap strings end to end, winding, coloring, weaving, braiding and sorting colors. Practically the same problems can be worked out with the use of rags. Two patients who in the past have been destructive are now kept busy cutting and tearing rags in-



A view of the occupational therapy work of the Southeastern Indiana Hospital for the Insane on exhibit at the Indiana Health Exposition last spring.

yet no work has been done for the men. Later when the work became better established classes were organized on four other wards. Gymnasium classes were met weekly for four different groups of patients in the chapel or on the lawns.

In the four classes formed on the wards, arrangements were made to combine two wards for each class. There work of varying complexity was taught. Carpet rags,

stead of their clothes. One of them tears the cloth into tiny bits with her fingers and another uses scissors to snip it into fine scraps. Spool knitting, various kinds of weaving and basketry are all used. The plan in all this work is to establish better habits of thought and action and as soon as one is firmly fixed to go on to something more complicated.

In addition to this work, the patients once or twice





Calisthenics on the lawn is being employed in the treatment of these backward patients.

each week are taken to the chapel where they are given physical exercises and games varying in complexity according to their mental level. For some groups this work consists wholly of marching, hand ball, drop the handkerchief and other games. As soon as they master these simple exercises they are given something more difficult to do, such as calisthenics or folk dancing. Most of the patients look forward to these exercises and the effect has been to raise the morale of the wards, for they know that if their conduct is violent it will not be possible to take them from the wards. Thus all of those excepting the ones who are really confused and disturbed are encouraged to control their emotional reactions and to keep neat and clean in person.

Work outside the classes and the women's industrial room is often prescribed for certain patients by the medical staff. They are provided with work of use to the hospital and then shifted as their mental condition changes. For example a girl may be given work in the diet kitchen and as she improves or proves capable be transferred to the officers' kitchen or dining room. Often girls are given the advantage of thorough domestic training in the household of the superintendent of the institution before being

sent home. Another part of the work which might be mentioned in the gardening class of ten patients taken in hand by Dr. Carrie Davis. The garden did not make much of a showing but the class itself is a great success.

From January 1 until the first of June, 147 patients out of a total of 588 or twenty-five per cent were reached by the classes in gymnasium and habit-formation. Thirty-two others were working steadily in the industrial room. Considering the fact that the greater part of the hospital work is done by patients and that these workers are not often included in the class work, the department has done well to reach this large percentage of the patients.



Where formerly they tore their clothing, these two destructive cases of dementia praecox are now tearing and cutting rags into tiny bits.

It is not only in finished undertakings that we ought to honour useful labour. A spirit goes out of the man who means execution, which outlives the most untimely ending. All who have meant good work with their whole hearts, have done good work, although they may die before they have the time to sign it. Every heart that has beat strong and cheerfully has left a hopeful impulse behind it in the world, and bettered the tradition of mankind.—R. L. Stevenson.



A class of deteriorated patients on one of the ward porches doing work varying in complexity from raveling burlap to knitting, crocheting and hand sewing.



A group of deteriorated patients learning to play "drop the handkerchief." If left alone they would be sitting on the wards indifferent to all surroundings.



COMPLETE oral hygiene as practised by nurses and other attendants is not only recognized as good administration, but is a necessary precautionary measure adopted by medical directors, superintendents and superintendents of nurses in the safeguarding of patients.

Interest in sanitary, healthy mouths of hospital personnel grows steadily. The subject will receive even more attention in the future.

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## OCCUPATIONS OF THE INSANE\*

BY J. C. SPURZHEIM, M.D., LICENTIATE OF THE COLLEGE OF PHYSICIANS OF LONDON, AND OF THE UNIVERSITIES OF VIENNA AND PARIS.

ALL practitioners who have taken care of insane people agree with respect to the usefulness of employment. It is, indeed, a fact that in those asylums for the insane, where labor makes a part of the regimen, a greater number of patients recover. Is it then not surprising that this important point is so little attended to in the erection and management of mad-houses?

Sufficient occupation of the mind is beneficial in two respects, in point of cure, and economical advantage. In the healthy state of the mind, idleness is the mother of many disorders, and in many insane, from want of suitable occupation, the disease is nourished; the patients indulge in their fancies, and injure their health by want of bodily exercise. In the asylums for the insane, however, we meet many persons of both sexes, vigorous, strong, and in many instances fully capable for manual labor. They loiter away their time in apathy and live often at the expense of the institution, while many economical concerns and the necessary affairs of the house might be done by such patients. Many, from previous habits, could be employed in the handicraft line, as whitewashers, carpenters, and tillers; others ought to be employed in the ordinary concerns of horticulture and husbandry, in digging, planting, weeding, wheeling; some might be employed in sowing, stone-cutting, twining ropes; female patients in washing, mending, getting up the linen, etc. It has been observed that, in all institutions for insane, the male patients who assist in cutting wood, making fire, and digging in the garden, and the females who are employed in washing, ironing, and scrubbing floors, often recover; while persons, whose rank exempts them from performing such services, languish away their life within the walls.

### Occupation Necessary for Convalescents

It is understood that the labor ought to be relieved by sufficient rest, by recreation and amusement. The fatigue of the day would prepare the laborers for sleep and repose during night. Many individuals are very solicitous for some kind of occupation, and during their employment in moderate labor they never fail to enjoy a more happy state. It is evident that the temperature of the atmosphere is attended to at the same time. The rich ought to exercise the fine arts, ought to be amused with various games, such as bowling, cricket, billiards, and in general with such occupations as keep body and mind in activity. We meet, in many institutions, drawings of various kinds made by patients. Dr. Hallaran, therefore, wishes "to pay the earliest attention to the capacity of every individual, in order to ascertain, at the period of convalescence, the practicability of employing the mind by any species of bodily exertion."

Occupation is particularly necessary for convalescents. To that end, I propose for them a separate building, with workshops for handicraftsmen, with grounds for tilling, and every other sort of occupation and amusement. The rich may cultivate music and painting, may read aloud entertaining books of history and travels, may walk and play. In what a dreadful situation must a man find himself, when, returning to reason, he sees himself surrounded by persons under all the different gradations of mental misery.

\*The writer died in the year 1834, but his suggestions are still timely and show what advanced ideas he held.

I could quote many facts in support of the truth that the insane more easily recover if body and mind are occupied. I shall copy only one fact from the work of Dr. Hallaran. "A young man, who had been an entire stranger at Cork, and who was remitted from a distant part of the country to the asylum in the usual form, came under my care in the state of acute mania, and continued so full three months without any intermission. The symptoms having at length given way, he was treated as a convalescent patient, and every means tried to encourage him to some light work, merely as a pastime, but all to no purpose. Though the maniacal appearance had totally subsided, he still betrayed an imbecility of mind that bordered closely on dementia, and it was found impossible to excite in him the smallest interest either for himself, or, in any measure, for that which had been proposed for his amendment. This man had nearly been ranked amongst the incurable idiots of the house, when by accident he was discovered in the act of amusing himself with some rude coloring on the walls of his apartment. From the specimen he had then given, he was questioned as to his knowledge of drawing; and he, having signified some acquaintance with that art, was immediately promised colors of a better description if he would undertake to use them. This evidently gave immediate cheerfulness to his countenance, and he shortly evinced an impatience for the indulgence offered to him. On his being furnished with the necessary apparatus for painting, he immediately commenced a systematic combination of colors, and having completed his arrangement, he requested one of the attendants to sit for him. This essay was sufficient to satisfy me that his recovery was not so remote as I had reason to suppose. The portrait was an exact representation of the person who sat before him; and in a few days there were several other proofs of his skill in this line, which bore ample testimony of his ability. He soon became elated with the approbation he had met with, and continued to employ himself in this manner for nearly two months; after which progressive improvement as to his mental faculties took place; when he was dismissed, cured, under the protection of some gentlemen amateurs, who took a kind interest in his preferment. He pursued his profession of miniature painting in this city for some time after, and has since, as I understand, removed to London where he practises it with singular success."

As the public establishments are not properly adapted to occupy the insane, it confers the more honor on the superintendents and managers who pay particular attention to this point and make the best use of the situation to which they are reduced by the plan of the architect.

What I must do is all that concerns me; not what the people think. This rule, equally arduous in actual and in intellectual life, may serve for the whole distinction between greatness and meanness. It is the harder, because you will always find those who think they know what is your duty better than you know it. It is easy in the world to live after the world's opinion; it is easy in solitude to live after our own; but the great man is he who in the midst of the crowd keeps with perfect sweetness the independence of solitude.—Emerson.

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## A POST-HOSPITAL COMMUNITY FOR THE HANDICAPPED

[A New Jersey plan that will be watched with interest is described in the following article. This or some similar organization will succeed some day in combining care and treatment of the handicapped with an opportunity to earn at least a partial self-support. Sound business management will be necessary for even a moderate return on money invested. The editors would like to see a small factory turning out a staple product established in association with a sanitarium for chronic invalids or convalescents. Certainly the out-of-door work of a farm would be valuable as affording healthful exercise for those who could bear the hard work. We would like to suggest green house work as suitable for all the year employment for certain classes of the handicapped.]—EDITORS' NOTE.

**T**HE post-hospital community for the handicapped opened in June is located in the Somerset Hills, thirty-five miles from the city of New York, eight miles from Morristown, N. J. (13,000 pop.), and two miles from Bernardsville, N. J. Both the latter towns are reached by the excellent service of the Lackawanna railroad.

It centers around an industrial plant incorporated under the laws of the state of New Jersey, with a capital stock of \$75,000, for the purpose of "providing post-hospital labor in handicrafts, and other handlabor for handicapped men and women." It does not include the tuberculous or the blind, but those physically crippled or disabled in other ways, chiefly the civilian handicapped who have been disabled through disease, injury or industrial accident.

Between the time of discharge from the hospital and a later return to normal industrial life lies a disastrous period for many people who have no home to go to and no money for maintenance, who are still unable to get back and forth to a job could one be procured, and who need physical upbuilding and renewed courage to meet a cripple's difficulties in earning a living. It is during this time that many become hopelessly pauperized and burdens upon city and state. The benefit gained by hospital care is frequently lost altogether, and the man or woman goes to the industrial scrap heap for lack of intelligent help at the right moment. The problem of this mental, moral and physical waste is increasingly important and especially acute just now.

### Organized on Basis of Self-Help

That this need exists and is not covered by any existing organization is attested by letters from hospitals and social service organizations of all kinds. Excerpts from one or two of these are appended. The instant and widespread approval from those who know conditions also attests the practicality of the work. The corporation seeks to avoid duplication of effort, and to cooperate with any individual, institution, business or social agency which is interested in someone it may help.

It is organized on the basis of immediate self-help, taking the man and woman directly upon discharge from the hospital and offering, not charity, but a chance to earn at least maintenance until such time as they are able to return to normal industrial life. We do not take medical or surgical cases, and it is necessary that all workers be able to do a minimum of four hours' work a day, which will cover actual maintenance.

The handicapped are offered a market for such abilities as remain to them and instruction along practical lines. The aim is to restore them, as early as possible, to economic independence, and for this purpose we cooperate with such organizations as the Institute for Crippled and Disabled Men for further vocational education if needed and for placement in industrial positions. In the event of their being too heavily handicapped ever to cope with in-

dustrial conditions outside, they can frequently be taught to do certain sorts of work with us which will cover their living and enable them to remain on a self-supporting and self-respecting basis, without having to face the future as burdens on their families or society.

There is no discrimination as to color, creed or nationality.

### Workers Govern Themselves

The workers are self-governed, establishing and enforcing their own discipline. As the ultimate success of the enterprise has a vital bearing on their own welfare and future, they are alert to protect themselves from the unworthy applicant.

The board of directors is made up of business men and executives. The work is planned around the central factors of success, excellence of product and adequate market. At present the industrial products is confined to certain kinds of wood-working, textiles, and wrought metal, which are fitted to the capacities and limitations of the handicapped worker. For these a market is already secured. Other work afforded consists of truck and poultry raising for our own use, clerical work, and the various duties connected with running the place. The group of workers forming the nucleus were all trained last winter to fit into their places.

An added source of revenue comes from a group of private patients who will pay sanitarium prices and be luxuriously housed in the administration building, 300 yards from the workshops and dormitories where they can have all the advantages of a convalescent sanitarium without its disagreeable features. They are sent to us by the orthopedic surgeons who wish them to have the benefit of occupational therapy.

The buildings were erected in 1913 at a cost of \$350,000 and are exceptional in their solidity, durability and suitability to the needs of the enterprise. They are well provided with heat, light, baths and telephones. The main house is used for administrative purposes. The exceptionally large building of two stories and basement, which was formerly the garage and stable, remodeled inside and provided with the special conveniences needed by the disabled, makes an ideal workshop and dormitory building. The twenty-five acres of land afford, in addition to the truck, poultry, etc., various earning facilities as yet undeveloped. The adjoining farm of ninety acres with farm buildings, stock and implements is being held at our option for a year at a very reasonable price.

### Details of Organization

The stock is common, (no preferred stock or bonds); it is sold at \$25 par. It is sold with the proviso that it may eventually be bought back by the corporation and the income used to further the work.

The corporation owns the realty free and clear and will have sufficient money in the bank for a year's budget. If, at the end of that time, it should be deemed best to discontinue the work, the realty is saleable enough and its value so far in excess of the amount of capital stock as to make it readily possible to return the stockholders their money. The stockholders are thus fully protected and are guaranteed one of three things:



*"America's Most Famous Dessert"*

# JELL-O



GALLON SIZE

EVERYWHERE hospital buyers are insisting on Jell-O because they find our Institutional size Jell-O is not a mere bulk product but that it is of exactly the same quality that has distinguished our domestic size package for so many years.

## Diabetic Jell-O

WE are now prepared to furnish direct to physicians a new product which is sugar free, and of low protein content. It is an appetizing addition to the dietary in diabetes, glycosuria and obesity. Correspondence is solicited. All letters should be addressed to the attention of our Chief Chemist.

THE GENESEE PURE FOOD COMPANY  
Le Roy, New York

- (1) Interest and dividends for a period of years.
- (2) Re-purchase by the corporation at the end of the first year, or
- (3) At the end of the first year, their money back with interest to date.

We feel that the investment offers no more risk than a large proportion of stock already on the market; in addition to that fact, every share sold helps some man or woman in a difficult struggle for a decent, useful life. Each one of the initial group has good brains, ambition and self-respect, but for every one this opportunity means salvation from Welfare Island or worse, while for several this prospect ahead turned the scales between life and death.

Stockholders and those standing back of the work include Miss Barger, sister of the treasurer of the New York Central Railroad; Mrs. Henry Villard, daughter of William Lloyd Garrison; Dr. Charles Jaeger, the well-known orthopedic surgeon; Rev. William Whiting Davis; R. Burton-Opitz, M.D., College of Phys. & Surg. and Columbia University; and Dr. Winford H. Smith, director of Johns Hopkins Hospital, Baltimore.

The Board includes the following: George F. Clover, executive head of St. Luke's Hospital, New York; James Morey of Lakewood and New York; Standish Chard, corporation lawyer; John Culbert Faries; Kenneth V. Carman and others equally in touch with business problems.

The following excerpts from letters indicate the need of such a community:

"That the plan is organized on a business, rather than a charitable basis, seems to me to commend it at once as valuable. The great need of some development of this sort is too obvious to need comment."—From Annie W. Goodrich, Department of Nursing and Health, Teacher's College, Columbia University, and Director of Nurses, Henry Street Settlement, New York.

"Your proposal occupies the safe middle ground between pauperizing charity and hard-hearted indifference.

"Even the best of us—the strongest I mean—sometimes wonder whether the struggle is worthwhile. How much more heavily must this doubt bear upon the worker who is struck down by illness or accident, whose moral and physical strength has been sapped by pain and whose connections with business and industry have been broken.

"It seems to me your plan will make men over. . . . I wish you every possible success."—Edgar Dawson, M.D., Professor of History and Political Science, Hunter College of the City of New York.

"I am firmly convinced of the fact that there is great need for machinery for dealing with the physically handicapped. Your conception of the plan by which to meet this need is excellent. . . . Furthermore, I believe that the establishment of such machinery is very necessary to supplement our hospital system, in order to make possible the carrying through of medical treatment to a conclusion, which restores the patient to full usefulness."—Winford H. Smith, M.D., Director, Johns Hopkins Hospital, Baltimore, Md.

The managing director, Miss Spencer, has devoted several years to special preparation for this work, in addition to long study of arts and crafts, here and abroad. She has lectured and written on the subject and has her diploma in occupational therapy from Teachers College, Columbia University. Recently she has made a practical first-hand study of the needs of handicapped workers, having taught for a year in a hospital for chronic diseases and done executive work in other institutions.

## BYRDCLIFFE SCHOOL HAS SUCCESSFUL SUMMER COURSE

By KATHRYN ROOT, Medical Workshop, Stamford, Conn.

The Byrdcliffe School of Occupational Therapy concluded its 1922 session on August 31. The school was conducted this year by Miss Bertha Thompson, a resident of Woodstock, a master craftsman, and an experienced occupational therapist. She was assisted by Miss Zelma Steele and Mr. Edward Thatcher, also of Woodstock. Both of these latter are professional craftsmen of great skill and considerable reputation and were valued instructors in the school in 1921.

The courses given were in basketry, clay modeling and

pottery, wood-carving, leather tooling, tin-can toys and copperwork, weaving and a group of minor crafts.

No pupil was permitted to carry more than three subjects, each of which had to be pursued for at least a month—two months, if desired—an arrangement which insured the acquirement of a reasonable degree of proficiency in the crafts chosen. The efficient organization of the school made it possible for each student to progress as rapidly as her capability and inclination determined, and allowed her to concentrate on the subject which she personally needed, a matter of great importance to an aide with limited time for post-graduate study.

With this freedom, Miss Thompson combined thoroughness, requiring that each process be clearly understood and carefully executed.

The class of 1922 has proved the summer work well worth while and advises any aides who need further training in the crafts to go to Woodstock next summer.

## THE ROLL CALL

### MEMBERS IN STATE SOCIETIES

ILLINOIS	NEW YORK
Active . . . . . 54	Active . . . . . 160
Associate . . . . . 2	Supporting . . . . . 47
MANITOBA	ONTARIO
Active . . . . . 30	Active . . . . . 95
Associate . . . . . 12	PENNSYLVANIA
Honorary . . . . . 2	An association of occupational therapy is being organized. At the present 20 aides in active service have joined, and it is expected that the association will grow rapidly.
MARYLAND	WASHINGTON, D. C.
Active . . . . . 75	Active . . . . . 30
MASSACHUSETTS	Associate . . . . . 2
Active . . . . . 149	WISCONSIN
Sustaining . . . . . 27	Active . . . . . 50
Life . . . . . 12	Associate . . . . . 6
MICHIGAN	Sustaining . . . . . 4
Active . . . . . 30	Honorary . . . . . 5
Associate . . . . . 10	
MISSOURI	
Active . . . . . 28	
Board . . . . . 11	
Sustaining . . . . . 124	

## A CALIFORNIA DESERT ROMANCE

Once upon a time a traveler went forth to assist some friends who had gone on before him and lost their way in the California desert. He provided himself with food, filled his canteen with water and started on his way armed with the hope that his steps would be guided in the right direction. But the days went by, he found no trace of his friends and he lost his way. Then his supplies gave out and no more water could be found. He stumbled about in his misery until all hope had gone when he lay down to take death as he thought it had come. But it did not come. Instead a kind stranger found him and took the dying man to his camp which after all was not very far away. There he was fed and refreshed and directed back to the home he had left, which he reached in safety, his heart troubled over the loss of the friends who never were found but filled with gratitude to the stranger who had befriended him. After many years time brought the traveler and the stranger together again, when they met at Olive View, a branch of Los Angeles County Hospital, and the traveler, Mr. James M. Lewis, steward's assistant, who has been at that institution since its opening day, recognized the good Samaritan, Mr. Lester J. Newberry, who has been just now appointed general maintenance man. This story has been enacted many times in Death Valley but never, we venture to say, with such a happy conclusion.—From the *News Bulletin* of the Department of Charities, Los Angeles County, Cal.

# Kirsch "Fresh Air" Swinging Curtain Rod

*The ideal rod  
for hospitals*

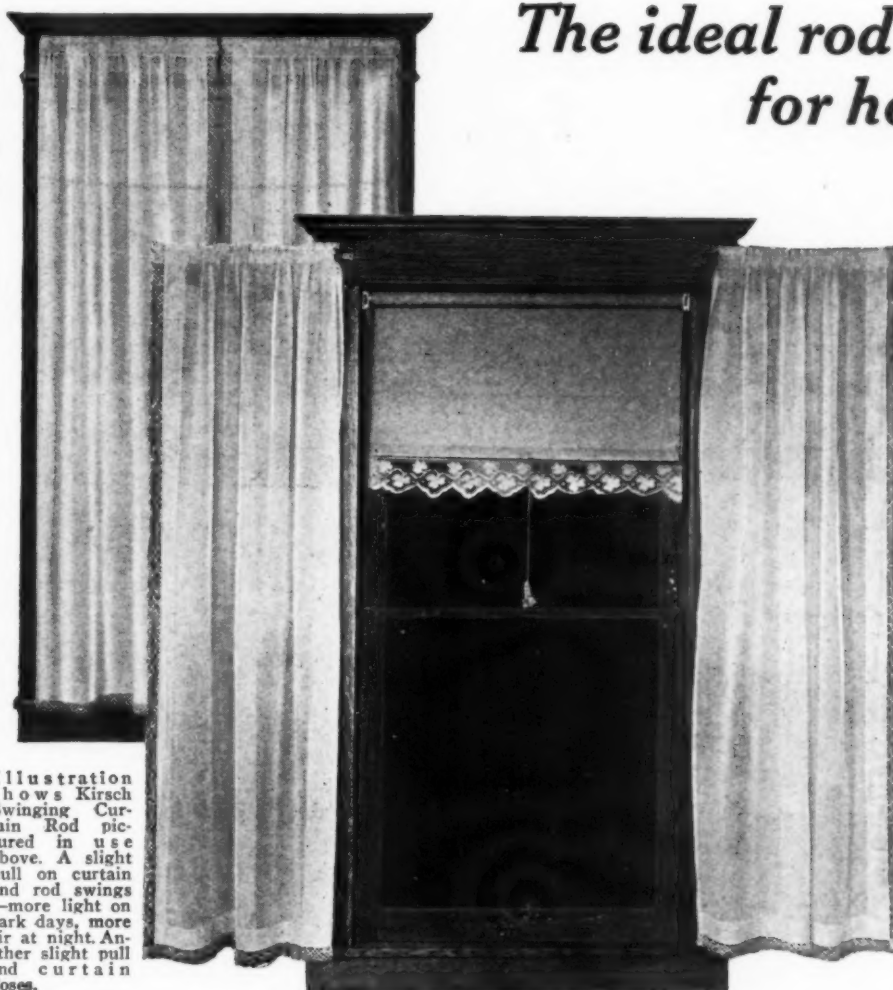


Illustration shows Kirsch Swinging Curtain Rod pictured in use above. A slight pull on curtain and rod swings—more light on dark days, more air at night. Another slight pull and curtain closes.

Simplicity itself.

Kirsch "Fresh Air" Swinging Curtain Rods permit the curtains to be swung open, insuring perfect ventilation.

They give the same draping effects as the regular line of Kirsch Extension and Cut-to-fit Curtain Rods.

***There's a Kirsch Rod to fit every window and to give any draping effect.***

Kirsch Curtain Rods are the most popular window draping fixtures and in the greatest demand.

Their flat shape provides ideal support for curtains. The Velvetone Finish stays like new indefinitely.

## Write for catalog and full information

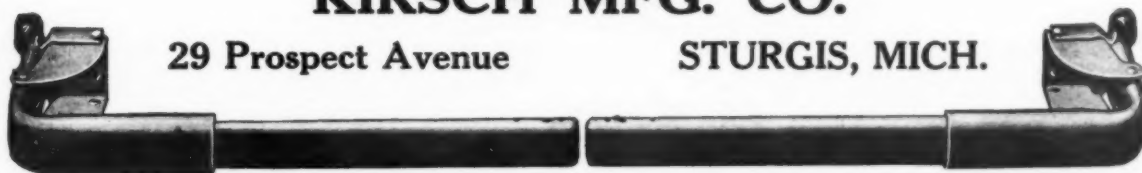
Our institutional department is maintained for the very purpose of giving desired information to hospitals and other institutions. Any questions gladly answered without obligation.

Catalog fully describes the Kirsch Swinging "Fresh Air" Curtain Rod, as well as our other rods. Gladly mailed on request.

### KIRSCH MFG. CO.

29 Prospect Avenue

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## MEETINGS, CONVENTIONS AND CONFERENCES

### DIETITIANS HAVE INTERESTING ANNUAL SESSION

AS REPORTED BY MISS MARION PETERSON, SUPERVISOR OF ADMINISTRATION, DEPARTMENT OF DIETETICS, LAKESIDE HOSPITAL, CLEVELAND, OHIO.

THE fifth annual meeting of the American Dietetic Association was held in Washington, D. C., October 16-19, at the New Willard Hotel. Registration began at 9 a. m. Monday morning, and the opening session was called to order at 10 a. m. by the president, Mrs. Mary de Garmo Bryan. After a few words of welcome, Mrs. Bryan turned the meeting over to the chairman of the education section, Dr. Ruth Wheeler, professor of dietetics, University of Iowa Medical College, Iowa City.

Dr. Wheeler told briefly of the work of this section, and introduced Mrs. Agnes O'Dea, Johns Hopkins Hospital, Baltimore who gave an interesting history of the dietitian, showing the rapid development of her position from the early time when she was a wholly untrained and unspecialized individual to the present. Today we find the dietitian highly specialized and excellently trained, organizing and administering large departments of dietetics.

Miss Breta Luther, dietitian at Children's Hospital, Boston, Mass., presented a report of a survey which the committee made to determine the nature of courses offered to student dietitians and student nurses in hospitals. The courses for student nurses varied from a course of twenty hours to one of ninety which was being offered some hospitals. It was suggested that the course should be broad, with class periods not to exceed two hours. There should not be a large amount of outside reading, nor should the endurance be overtaxed by too frequent reviews. The work must be thorough and carefully planned, and presented in the most interesting manner. The committee outlined a course for student nurses, and copies of this were on sale at the information booth.

#### Recommends Nine-Month Course

Dr. Wheeler next spoke of the "Dietitian of the Future." From her grandmother, the dietitian gets her reserve, her good health, her poise, and her general good physical condition and to these inherent qualities she adds a degree from a recognized college or university with a major in home economics. She must have a broad scientific training with a thorough knowledge of metabolism. She must also be trained in organization, in practice and management, in care of food supplies and modifications of diet. The dietitian may be a technician, or a specialist in dietetics in a food clinic. She must take time to prepare for her administrative power. Institutional housekeeping and teaching nurses cannot be covered in a three months' course of training. Salary and rank are not important in the beginning.

Miss Emma Gunther, Teacher's College, Columbia University, told of conditions in China, in a most interesting way. She said, that the Chinese have an experimental and an open mind, and are eager to learn. Miss L. Ray Balderston, Teachers' College, Columbia University, discussed the housewife's problems in China.

The first speaker at the afternoon session was Dr. Elliot P. Joslin of Boston, who emphasized the relation between the dietitian and the diabetic. Overfeeding of the diabetic should be carefully avoided, since this condition only intensifies the symptoms. The function of the dietitian is to educate the patient, and see to it that his diet is very strictly adhered to. It is not necessary to teach him to figure the diet to the smallest fraction, but he can learn how to plan his diet in the easiest and most practical way.

Dr. P. L. Marsh of the University Hospital, Ann Arbor, Mich., discussed "The Construction of Diabetic Diets in Accordance with Metabolic Laws." His first principle is that the actual material metabolized is not identical with the food given, even though it be completely digested. Therefore fasting for desugarization is illogical, because you can't have an actual metabolic rest.

Dr. J. W. Hayes, Howell Publishing Co., New York, in his paper on "Psychological Aspects of Some Problems in Administration," spoke of the psychology of behavior, and said that there is a definite relation between people that work. Personnel management means a job well done by a satisfied worker. We must adjust the job to the man and the man to the job. The relation of a man to his job pertains to the psychology of adjustment. The health of the individual is largely dependent upon a correct adjustment.

Miss Laura Comstock of the Eastman Kodak Company, Rochester, N. Y., told of the "Nutrition Experiment in Industry" in their plant, where the underweight and undernourished office workers are all given a pint of milk a day furnished by the company. They have frequent conferences with the dietitian, tell her their trouble, are weighed and examined frequently, and the results are very satisfying. So far the work has been done with the office people only, but it is to be extended to the factory workers in a very short time.

Monday evening all delegates, members and friends gathered in the assembly room for dinner. The president, Mrs. Bryan, gave a history of the association from the time of its founding to the present, told of the many things it has accomplished, and the many plans its mem-

CASTLE

## "Any Sterilizer Troubles Today?"

*(The Hospital Superintendent and the Surgical nurse were talking—Series V)*

"Yes, Doctor, those sterilizers in the Maternity Department are all out of kilter again."

*"But we just overhauled them in the spring."*

"I know, but they just don't stand up. The instrument sterilizer leaks again; it takes two girls to get the tray out of the utensil sterilizer, and we simply can't melt Diack Controls in the dressing sterilizer."

*"How long have you had those sterilizers, Miss Smith, and how much did they cost."*

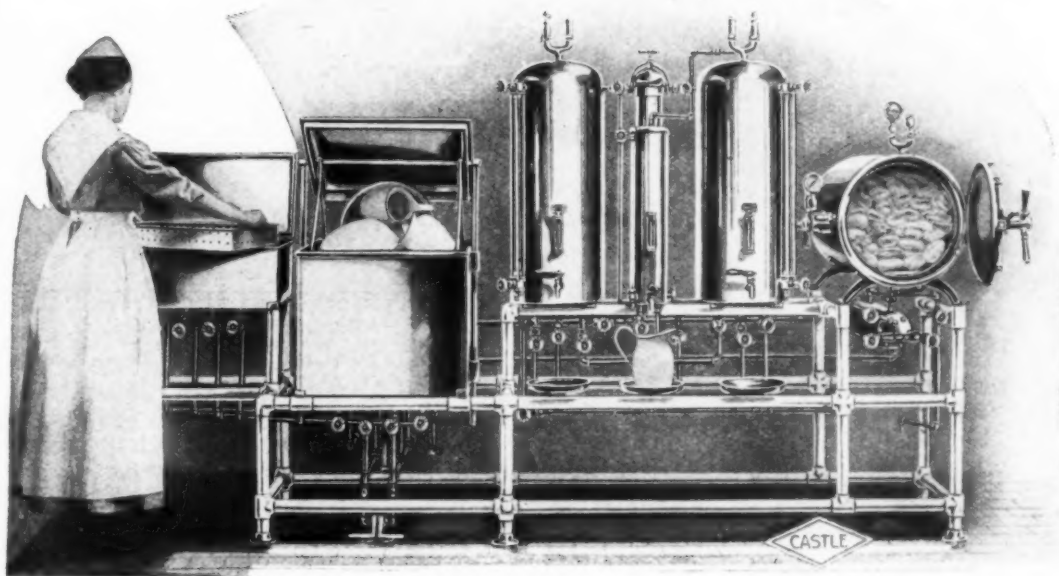
"Six years, and we paid \$1100."

*"They were cheap, but how much for repairs?"*

"About \$400.00."

*"Good Heavens! They're luxuries. We can't afford them. Those Castle Sterilizers, on the other hand, have been in almost as long, seen twice as much use and the total repair bill is \$5.00 for a new thermometer. Get a price on what you need from the Castle people, Miss Smith, and if we have enough money left at the end of the month we will buy them."*

"All right, and I'll send them a sketch of our room and let them suggest the right arrangement. There is no charge for that."



*Send for Castle Sterilizer Specifications*

**WILMOT CASTLE COMPANY, 1151 University Ave., Rochester, N. Y.**

*Makers of the largest line of Sterilizers for Hospitals, Laboratories, Physicians and Dentists*

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bers have for future development. Asst. Surgeon General F. C. Smith in a delightful talk traced the dietitian back to ancient countries and times and found her counterpart everywhere. He also spoke of the excellent work the dietitian did in the war.

Maj. Julia Stimson, chief of the U. S. Army Nursing Corps, suggested ways in which the American Dietetic Association can grow and thrive. She suggested a placement bureau, which the A. D. A. already has and also an executive office, with an executive secretary.

Miss Minnegerode of the U. S. Public Health Service told of the work of that organization, and spoke of the work of the dietitian in that group. Miss Clara D. Hayes of the American Red Cross told of the Red Cross dietitian service, of how it had been started under the nursing service, but had grown until at present it has offices of its own, and is a separate organization. Mrs. Hallie B. Corsette spoke of the work of the dietitians in the Public Health Service, of the spirit of service which is so evident, and the cooperation they are getting in this work. Col. Merritte W. Ireland thanked the dietitians for their work in the recent war, told of the importance of the dietitian and of what she means to the army hospital.

The meeting Tuesday morning was opened by Miss Rena S. Echman, director of housekeeping and dietetics, University of Michigan Hospital, Ann Arbor, Mich. The session was a joint meeting of the sections of dietotherapy and administration.

Dr. L. H. Newburgh of the University Hospital, Ann Arbor, read a most interesting paper on "The Role of High Protein in the Etiology of Nephritis." He said that in a search for the cause of nephritis, the theory of bacteria has been discarded except in some cases of the very young and acute cases where it could be absolutely traced. In 1916 the theory of wrong diet was carefully studied, and some rigid experiments were made with egg white casein and soy bean protein. Lesions occurred in six months, also albumen in the urine and the kidneys was increased. This was true of the soy bean meal as well as of the animal proteins, showing that an excess of vegetable protein is also detrimental.

Miss Dorothy Stewart of the University of Michigan Hospital, Ann Arbor, read a most interesting paper telling of the "Technical Preparation of Special Diets." They have just opened up a new metabolism ward made from an old ward diet kitchen. At present most of their diets are diabetic. The diets are all weighed, prepared and served directly to the patients from this metabolism kitchen. They have a graded system of diets.

Dr. LeRoy E. Parkins, assistant superintendent of Peter Bent Brigham Hospital, Boston, in an interesting paper, emphasized the fact that hospital food costs include cost in money, labor and thought.

The concluding paper of Tuesday morning's session was by Henry C. Wright of the Hospital and Institutional Bureau of Consultation, New York, on "Getting Food to the Patients." The first thing of importance in this connection, says Mr. Wright, is to safeguard the patients from the noise and odors of the serving room.

Delegates on Tuesday afternoon enjoyed inspection tours to the Walter Reed General Hospital and to the Agricultural Bureau, Office of Home Economics, and government hotels.

Miss Octavia Hall of Peter Bent Brigham Hospital, Boston, presided at the session on Tuesday evening. Mrs. Mary Schwartz Rose of Teachers' College, Columbia, presented a helpful paper on "Nutrition and Diet in Childhood" in which she enumerated several experiments

with children. Her recommendation was that each child get a full quart of milk a day, in addition to other easily digested and nourishing foods.

Dr. Alfred Hess of New York talked on "The Relation of Hygiene to the Growing Child." His remarks were based for the most part on an exhaustive study of rickets, which shows that there is practically no rickets in summer, while there is a great deal in winter. This he attributed in some degree to lack of sunlight and urges that children not be wrapped up too tightly. Whenever possible their limbs should be exposed to the sunlight, he says. He further noted the use of tomatoes as a preventive measure for scurvy.

The report of Mrs. Gertrude S. Mudge's committee on the Italian Dietary Survey on Wednesday morning was well received. It is to be printed and widely distributed.

"The Interrelation of the Dietitian and the Social Worker" was the topic of a helpful paper by Miss Ida M. Cannon, director of social service at Massachusetts General Hospital, Boston. Good cooperation and loyalty between these two departments whose work so frequently overlaps was the theme of her address.

Fatigue, fear, excess exercise, no sunlight, too little sleep and bad teeth are some factors other than food that influence nutrition, said Miss Lucy Gillett, director of nutrition of the A. I. C. P., New York, in her address.

Philadelphia's outstanding work in nutrition activities was reviewed by Miss Anna Louise DePlanter of the Child Federation of that city. There are thirty-two classes for undernourished children in schools, hospitals and settlements in Philadelphia.

The fundamental motives, hunger and thirst, were discussed by Dr. Walter Cannon, professor of physiology at Harvard Medical School, in an illuminating address on Wednesday evening. Hunger, he declared, is distinct from appetite which is an interest in a previous experience. Hunger may be lessened by smoking, by hard exercise and by tightening the belt, but it returns again. Among the causes of thirst, he enumerated too much air, fear, fever, diabetes and other general causes.

At the business session on Wednesday afternoon the following officers were named:

President, Octavia Hall, Peter Bent Brigham Hospital, Boston.

First vice president, Mrs. Hallie Corsette, U. S. Public Health Service, Washington, D. C.

Second vice president, Miss Effie Raitt, Washington University.

Secretary, Miss Breta Luther, Children's Hospital, Boston, Mass.

Treasurer, Miss Anna Boller, Chicago.

Miss Genevieve Field presided at the Wednesday evening session. Addresses were given by Dr. Orton of the Department of Agriculture on "Vegetables for Diabetics" in which he stressed the possibilities of the more uncommon vegetables; by Miss Marjory Hulsinger of Barnes Hospital, St. Louis, on "The Food Service for Ward Patients;" by Miss Daisy Treen on "Food Service for School Children;" and by Miss Mary Lindsley, manager of the government hotels at Washington on "Food Service for the Hotel."

On Thursday a number of the delegates went to Baltimore where they enjoyed a special program at Johns Hopkins Hospital, had luncheon at that institution and inspected it and its clinics.

Exhibits at the fifth annual session were most interesting and the entire meeting was declared a great success. There were 293 dietitians registered.



The  
**ARISTON**  
Line

## STANDARDIZATION OF FOOD SERVICE IN HOSPITALS

IS  
**ALWAYS**  
Fine

### COCOA—*The Cold Weather Drink*

**C**OCOA comes from the bean of the cacao tree, as does chocolate also. The fat in the bean is called cocoa butter.

The largest producers are the Gold Coast, West Africa; Bahia, Brazil; Guayaquil, Ecuador. The largest consumers are the United States and Germany.

Cacao trees are planted 15 to 30 feet apart, begin to bear in four years, and may bear for 100 years. The yield is from 2 to 6 pounds of cured beans per tree. Pods have been known to weigh 3½ pounds, with 40 to 50 beans per pod.

The trees grow best at about 1,000 feet above sea level, and they require much moisture. Young trees require shade.

After the beans are gathered they require a week or more to dry thoroughly. They are then roasted and their shells removed. The nibs or kernels are ground with steam heated rollers, and the cocoa mass runs out in semi-liquid form.

The value of cocoa mass is determined by the percentage of its cocoa butter content.

Bitter chocolate is the cocoa mass with the butter fat left in it. Addition of sugar and vanilla flavor makes sweet chocolate.

Cocoa is made by reducing the percentage of butter fat. In our Ariston Cocoa the percentage is upwards of 22 per cent, making an agreeably rich beverage, truly nutritious.

The Ariston Cocoa is put up in 5-lb. friction-top cans, as also in 50-lb. and 100-lb. drums. Large quantity sales enable us to make very attractive prices.

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Coffees are roasted on orders as received.  
All goods sold are strictly guaranteed.  
All our goods are always pure and fresh.  
Prices are always reasonable and right.  
Packages of sizes convenient for institutions.

Sales are made direct, to institutions only.  
We give personal service on every order.  
Orders received by noon shipped same day.  
Special attention is given to mail orders.  
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1892

**CALUMET TEA & COFFEE COMPANY**

GEORGE W. WALSH, PRESIDENT

409-411 WEST HURON ST., CHICAGO, ILL.

1922

## MEETING OF MISSISSIPPI VALLEY CONFERENCE ON TUBERCULOSIS IS FRUITFUL

A SHORTAGE of more than 10,000 beds for proper hospitalization of tuberculosis patients exists in the twelve states of the Mississippi Valley, according to Murray A. Auerbach, executive secretary of the Indiana Tuberculosis Association in his address before the Mississippi Valley Conference on Tuberculosis held in Milwaukee on Oct. 9-11.

"Using the Framingham demonstration figures," Mr. Auerbach said, "there should be approximately 20,000 beds for tuberculosis patients in the Mississippi Valley states. There are available, actually 9,830 beds, less than 50 per cent of the number needed.

"As far as sanatorium capacity goes, this may appear to be a fairly good record. It is well known, however, that some states have made very little provision for the housing of tuberculous patients. To the large cities really goes the credit of establishing a fairly adequate number of beds; in fact six cities have provided about one-half of the number of beds now available in the valley."

The Mississippi Valley Conference on Tuberculosis, comprising workers in all branches of the tuberculosis field in the states of Wisconsin, Minnesota, North Dakota, South Dakota, Nebraska, Iowa, Missouri, Illinois, Indiana, Michigan, Ohio, and the city of Chicago, attracted a registered attendance of 400 delegates and a total attendance of approximately 700 persons. The conference was held in the Hotel Pfister. The last day of the meeting was set aside to sectional meetings, at which time the Mississippi Valley Sanatorium Association held its sessions at Muirdale and Blue Mound sanatoriums. Approximately 200 delegates attended these sessions.

Men and women of national reputation in the tuberculosis field addressed the conference, including Dr. Lawrason Brown, president of the National Tuberculosis Association; Dr. Linsley Williams, managing director of the National Tuberculosis Association; Dr. David T. Stewart, superintendent of Ninette Sanatorium, Ninette, Canada; Dr. M. P. Ravanel, bacteriologist and former president of the national association; Miss Adda E. Eldridge, president of the American Nurse's Association; Owen R. Lovejoy, general secretary of the National Child Labor Committee; and Dr. David R. Lyman, superintendent of Gaylord Farm Sanatorium, Wallingford, Conn.

### Dr. Patterson Heads Association

At the annual election of officers of the Mississippi Valley Conference, Dr. Robert G. Patterson, Columbus, Ohio was elected president; Mrs. Theodore Sachs, Chicago, vice president; James Minnick, Chicago, secretary and treasurer. Evansville, Ind. was chosen as the next convention city.

Dr. J. W. Coon, medical director, River Pines Sanatorium, Stevens Point, Wis. was elected president of the Mississippi Valley Sanatorium Association, and Dr. E. B. Pierce, superintendent, Michigan State Sanatorium, Howell, Mich., secretary-treasurer.

Two subjects of particular interest to institutional executives were that of care of the tuberculous criminal and the question of payment for sanatorium care on the part of the patient. Theodore J. Werle, Lansing, Mich. discussing "The Tuberculous Criminal and the Criminally Tuberculous" stated that many sanatoriums are having

trouble with patients sent to them for treatment from penal institutions over whom no adequate control can be exercised. This class, together with the occasional incorrigible patient, constitute a group for which provision should be made for separate housing, according to Mr. Werle. He further advocated the parole of prisoners suffering from tuberculosis so that they could be given proper medical attention with a proviso that they be returned to prison to complete their terms when a cure had been perfected.

Dr. George T. Palmer, Springfield, Ill., president of the Illinois Tuberculosis Association and medical director of the Palmer Sanatoria, Springfield, urged the placing of all public sanatorium beds on an absolutely free basis. Dr. Palmer stated that in all public sanatoriums for the treatment of tuberculosis in Illinois, the patient is treated without charge, regardless of social position and that an effort is being made to educate the public to think of free sanatorium care on the same basis as they would think of free schooling, and to eliminate from the public mind the idea that free sanatorium treatment classes the patient as a pauper.

### Says War Did Not Increase Tuberculosis

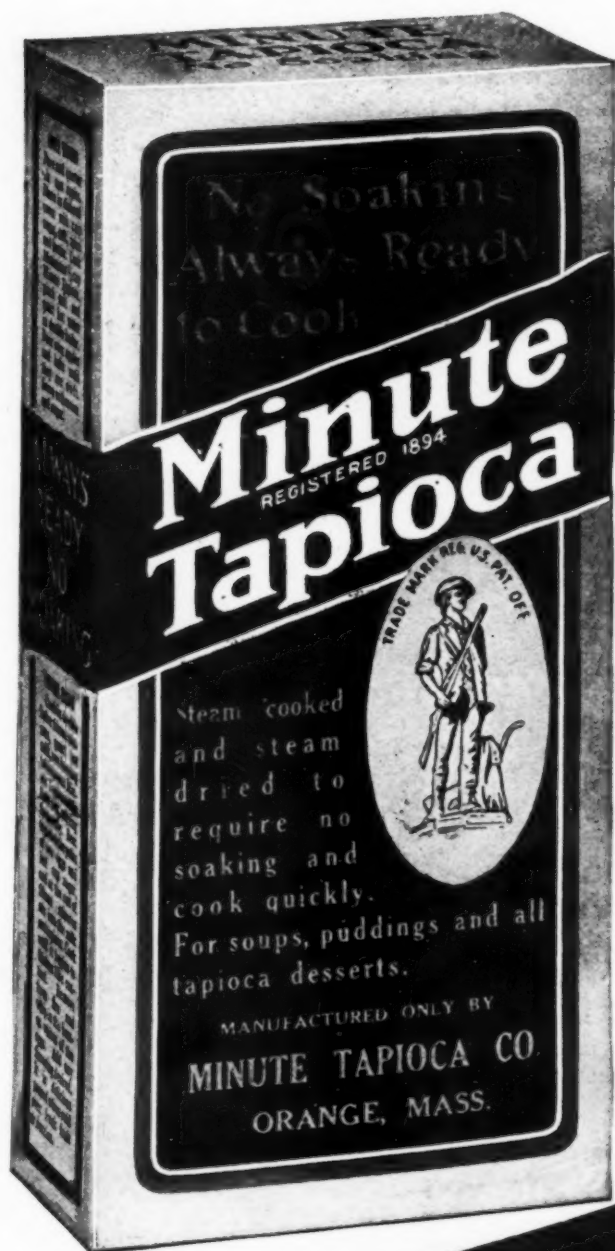
Dr. Palmer, who was one of five men in the United States selected by the government to standardize methods of diagnosis, examination and treatment in government sanatoriums, made the statement that "the war probably did not increase tuberculosis. The reason we have so much tuberculosis among soldiers, sailors, marines and nurses is because these groups have had so many physical examinations as compared to the civil population. Take a similar number of young girls and give them the same number of examinations given the soldiers and you will find just as much tuberculosis among them."

Dr. W. H. Watterson of the staff of the U. S. Veteran's Bureau Hospital No. 76, Maywood, Ill. presented the report of the committee on the problem of the tuberculous ex-soldier.

Miss Adda E. Eldredge, president of the American Nurse's Association, stressed the necessity of proper instruction of undergraduate nurses in tuberculosis work, recommending a closer affiliation between hospital training schools and tuberculosis sanatoriums, and demanding that a proper course of instruction be provided in the sanatorium after the affiliation had been completed.

A note of optimism carried through the entire conference. In the face of a steadily falling death rate, with the facilities for carrying on the fight broadening and constantly intensifying, it was natural that the delegates view the existing situation with satisfaction and optimism. Dr. David R. Lyman, superintendent of Gaylord Farm Sanatorium, Wallingford, Conn. in speaking before the annual dinner expressed the opinion that the fight against tuberculosis had reached the third stage. That the first or formative stage had been followed by the era of organization and with this foundation laid, the work was now launching into the third stage, that of accomplishment.

Dr. M. P. Ravanel, University of Missouri and a former president of the National Tuberculosis Association, recognizing the great accomplishments of the past and the reason for an optimistic view of the situation, added a needed note of caution.



## Look at the trays— they tell the story

There is no better evidence of what patients like to eat than that of the trays, after service.

Serve any one of the score of puddings made with Minute Tapioca. Then look at the trays when they come back to the kitchen. The empty dessert dishes show how well patients like Minute Tapioca. It is the kind of food they have at home, and they want it served often.

As an energy-producing food and one easy to assimilate, Minute Tapioca stands very high. Many leading hospitals list it as a staple item and are never without it.

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Student nurses and anyone who has anything to do with the preparation of food also approve of Minute Tapioca. It is always ready for use. It requires no soaking and can be cooked thoroughly in fifteen minutes.

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Makers of Minute Tapioca, Minute Gelatine, and Star Brand Pearl Tapioca



## LIST OF APPROVED HOSPITALS

*Continued from page 439*

- St. Luke's Hospital, Cleveland  
 St. Mary's Hospital, Cincinnati  
 St. Rita's Hospital, Lima  
 St. Vincent's Hospital, Cleveland  
 St. Vincent's Hospital, Toledo  
 Springfield City Hospital, Springfield  
 Toledo Hospital, Toledo  
 University Homeopathic Hospital, Columbus  
 Youngstown Hospital, Youngstown  
*50 to 100 beds*
- \*Alliance City Hospital, Alliance  
 Bellaire City Hospital, Bellaire  
 Bethesda City Hospital, Zanesville  
 Children's Hospital, Columbus  
 Children's Hospital and Mary Day Nursery, Akron  
 Deaconess Hospital, Cincinnati  
 Fairview Park Hospital, Cleveland  
 Flower Hospital, Toledo  
 Glenville Hospital, Cleveland  
 Good Samaritan Hospital, Sandusky  
 Lakewood Hospital, Cleveland  
 Lima Hospital, Lima  
 Mansfield General Hospital, Mansfield  
 Massillon City Hospital, Massillon  
 Maternity and Children's Hospital, Toledo  
 Memorial Hospital, Fremont  
 Mercy Hospital, Canton  
 Mercy Hospital, Columbus  
 Newark City Hospital, Newark  
 Robinwood Hospital, Toledo  
 St. Ann's Infant Asylum and Maternity Hospital, Cleveland  
 Salem Hospital, Salem  
 Scarlet Oaks Sanitarium, Cincinnati  
 Schirman Hospital, Portsmouth  
 Warren City Hospital, Warren
- OKLAHOMA**  
*100 or more beds*  
 St. Anthony's Hospital, Oklahoma City  
 State University Hospital, Oklahoma City  
*50 to 100 beds*
- \*Wesley Hospital, Oklahoma City
- OREGON**  
*100 or more beds*  
 Emmanuel Hospital, Portland  
 Good Samaritan Hospital, Portland  
 Hot Lake Sanatorium, Hot Lake  
 St. Vincent's Hospital, Portland  
*50 to 100 beds*
- \*Portland Sanitarium, Portland  
 Portland Surgical Hospital, Portland  
 Sacred Heart Hospital, Medford
- PENNSYLVANIA**  
*100 or more beds*  
 Allegheny General Hospital, Pittsburgh  
 Allentown Hospital, Allentown  
 Altoona Hospital, Altoona  
 Braddock General Hospital, Braddock  
 Chester County Hospital, West Chester  
 Chester Hospital, Chester  
 Children's Homeopathic Hospital, Philadelphia  
 Children's Hospital, Pittsburgh  
 Clearfield Hospital, Clearfield  
 Columbia Hospital, Pittsburgh  
 Conemaugh Valley Memorial Hospital, Johnstown  
 Easton Hospital, Easton  
 Elizabeth Steel Magee Hospital, Pittsburgh  
 Frankford Hospital, Philadelphia  
 George F. Geisinger Hospital, Danville  
 Germantown Dispensary and Hospital, Philadelphia  
 Hahnemann Hospital, Scranton  
 Hahnemann Medical and Surgical Hospital, Philadelphia  
 Hamot Hospital, Erie  
 Harrisburg Hospital, Harrisburg  
 Homeopathic Medical and Surgical Hospital, Pittsburgh  
 Hospital of the Protestant Episcopal Church, Philadelphia  
 Hospital of the University of Pennsylvania, Philadelphia  
 Hospital of the Women's Medical College, Philadelphia  
 J. Lewis Crozer Hospital, Chester  
 Jefferson Medical College Hospital, Philadelphia  
 Jewish Hospital, Philadelphia  
 Lancaster General Hospital, Lancaster  
 Lankenau Hospital, Philadelphia  
 McKeesport Hospital, McKeesport  
 Medico-Chirurgical Hospital, Philadelphia  
 Memorial Hospital, Philadelphia  
 Mercy Hospital, Johnstown  
 Mercy Hospital, Philadelphia  
 Mercy Hospital, Pittsburgh  
 Mercy Hospital, Wilkes-Barre  
 Methodist Episcopal Hospital, Philadelphia  
 Misericordia Hospital, Philadelphia  
 Moses Taylor Hospital, Scranton  
 Mt. Sinai Hospital, Philadelphia  
 Passavant Hospital, Pittsburgh  
 Pennsylvania Hospital, Philadelphia  
 Philadelphia General Hospital, Philadelphia  
 Philadelphia Polyclinic Hospital, Philadelphia  
 Pittsburgh Hospital, Pittsburgh  
 Pottsville Hospital, Pottsville  
 Presbyterian Hospital, Philadelphia  
 Presbyterian Hospital, Pittsburgh  
 Reading Hospital, Reading  
 Robert Packer Hospital, Sayre  
 Sacred Heart Hospital, Allentown  
 St. Agnes Hospital, Philadelphia  
 St. Francis Hospital, Pittsburgh  
 St. John's General Hospital, Pittsburgh  
 St. Joseph's Hospital, Lancaster  
 St. Joseph's Hospital, Philadelphia  
 St. Joseph's Hospital, Pittsburgh
- St. Joseph's Hospital, Reading  
 St. Luke's Hospital, South Bethlehem  
 St. Margaret's Hospital, Pittsburgh  
 St. Mary's Hospital, Philadelphia  
 St. Vincent's Hospital, Erie  
 Samaritan Hospital, Philadelphia  
 South Side Hospital, Pittsburgh  
 \*State Hospital for Injured Persons, Ashland  
 State Hospital of Middle Coal Fields, Hazleton  
 State Hospital for Northern Anthracite Coal Regions, Scranton  
 Washington Hospital, Washington  
 Western Pennsylvania Hospital, Pittsburgh  
 Wilkes-Barre City Hospital, Wilkes-Barre  
 Wills Hospital, Philadelphia  
 Women's Homeopathic Hospital, Philadelphia  
 Women's Hospital, Philadelphia  
 York Hospital and Dispensary, York  
*50 to 100 beds*
- Abington Memorial Hospital, Abington  
 Bainbridge Private Hospital, Philadelphia  
 Bryn Mawr Hospital, Bryn Mawr  
 Carlisle Hospital, Carlisle  
 Chestnut Hill Hospital, Philadelphia  
 Children's Hospital, Philadelphia  
 Children's Hospital of the Mary J. Drexel Home, Philadelphia  
 Citizens General Hospital, New Kensington  
 Gynececan Hospital, Philadelphia  
 Howard Hospital, Philadelphia  
 Indiana Hospital, Indiana  
 J. C. Blair Memorial Hospital, Huntingdon  
 \*Jewish Maternity Hospital, Philadelphia  
 \*Joseph Price Memorial Hospital, Philadelphia  
 \*Mercy Hospital, Altoona  
 Monongahela Memorial Hospital, New Eagle  
 Montefiore Hospital, Pittsburgh  
 \*Northwestern General Hospital, Philadelphia  
 Oil City Hospital, Oil City  
 Palmerton Hospital, Palmerton  
 Philadelphia Lying-in Charity Hospital, Philadelphia  
 Preston Retreat Hospital, Philadelphia  
 \*Providence Hospital, Beaver Falls  
 St. Christopher's Hospital for Children, Philadelphia  
 St. Luke's Homeopathic Hospital, Philadelphia  
 St. Vincent's Hospital for Women and Children, Philadelphia  
 \*State Hospital of Nanticoke, Nanticoke  
 Stetson Hospital, Philadelphia  
 Suburban General Hospital, Bellevue  
 West Philadelphia Hospital for Women, Philadelphia
- RHODE ISLAND**  
*100 or more beds*  
 \*Newport Hospital, Newport  
 Rhode Island Hospital, Providence  
 St. Joseph's Hospital, Providence  
*50 to 100 beds*  
 Memorial Hospital, Pawtucket  
 Providence Lying-in Hospital, Providence
- SOUTH CAROLINA**  
*100 or more beds*  
 Chick Springs Sanitarium, Chick Springs  
 \*Columbia Hospital, Columbia  
 Florence Infirmary, Florence  
 \*Greenville City Hospital, Greenville  
 Roper Hospital, Charleston  
*50 to 100 beds*
- \*Anderson County Hospital, Anderson  
 Baker Sanatorium, Charleston  
 St. Francis Xavier Infirmary, Charleston
- SOUTH DAKOTA**  
*100 or more beds*  
 McKennan Hospital, Sioux Falls  
 St. Luke's Hospital, Aberdeen  
*50 to 100 beds*  
 Lincoln Hospital, Aberdeen  
 Methodist State Hospital, Mitchell  
 New Madison Hospital, Madison  
 \*St. Joseph's Hospital, Deadwood  
 St. Mary's Hospital, Pierre
- TENNESSEE**  
*100 or more beds*  
 Baptist Memorial Hospital, Memphis  
 Erlanger Hospital, Chattanooga  
 \*George W. Hubbard Hospital, Nashville  
 \*Knoxville General Hospital, Knoxville  
 Memphis General Hospital, Memphis  
 Nashville City Hospital, Nashville  
 St. Joseph's Hospital, Memphis  
 St. Thomas Hospital, Nashville  
 Vanderbilt University Hospital, Nashville  
*50 to 100 beds*
- Baird-Dulaney Hospital, Dyersburg  
 \*Fort Sanders Hospital, Knoxville  
 Newell and Newell Sanitarium, Chattanooga  
 Women's Hospital of State of Tennessee, Nashville
- TEXAS**  
*100 or more beds*  
 Baptist Hospital, Houston  
 Baylor Hospital, Dallas  
 Central Texas Baptist Sanitarium, Waco  
 Hotel Dieu, Beaumont  
 John Sealy Hospital, Galveston  
 Parkland Hospital, Dallas  
 Providence Sanitarium, Waco  
 Robert B. Green Memorial Hospital, San Antonio  
 St. Joseph's Infirmary, Fort Worth  
 St. Joseph's Infirmary, Houston  
 St. Mary's Infirmary, Galveston  
 St. Paul's Sanitarium, Dallas  
 Santa Rosa Infirmary, San Antonio  
 \*Santa Fe Hospital, Temple  
 Temple Sanitarium, Temple  
*50 to 100 beds*
- All Saints Hospital, Fort Worth  
 Harris Sanitarium, Fort Worth

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**E**DELWEISS PURE PHOSPHATE Baking Powder—made after our special formula and under rigid supervision to obtain the utmost in purity and leavening qualities—has health sustaining properties which make it a vital necessity wherever baking is known. *These virtues lie particularly in its PHOSPHATE content.*

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WHOLESALE GROCERS Chicago

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POINTS



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King's Daughters' Hospital, Temple  
St. Joseph's Infirmary, Paris

## UTAH

100 or more beds

Dr. W. H. Groves' Latter Day Saints Hospital, Salt Lake City  
Holy Cross Hospital, Salt Lake City  
St. Mark's Hospital, Salt Lake City

\*Thomas D. Dee Memorial Hospital, Ogden

## VERMONT

100 or more beds

Mary Fletcher Hospital, Burlington

50 to 100 beds

Fanny Allen Hospital, Winoski  
Heaton Hospital, Montpelier

\*Rutland Hospital, Rutland

## VIRGINIA

100 or more beds

\*Chesapeake and Ohio Hospital, Clifton Forge  
Hospital Division of Medical College of Virginia, Richmond  
Norfolk Protestant Hospital, Norfolk  
St. Vincent's Hospital, Norfolk  
Stuart Circle Hospital, Richmond  
University of Virginia Hospital, Charlottesville

50 to 100 beds

Elizabeth Buxton Hospital, Newport News

Jefferson Hospital, Roanoke

Johnston-Willis Sanitarium, Richmond

\*King's Daughters' Hospital, Staunton

Lake View Hospital, Suffolk

Lewis-Gale Hospital, Roanoke

\*Riverside Hospital, Newport News

St. Elizabeth's Hospital, Richmond

St. Luke's Hospital, Richmond

Sarah Leigh Hospital, Norfolk

## WASHINGTON

100 or more beds

Children's Orthopedic Hospital, Seattle

Columbus Sanitarium, Seattle

King County Hospital, Seattle

Maria Beard Deaconess Hospital, Spokane

\*Northern Pacific Hospital, Tacoma

Providence Hospital, Seattle

Sacred Heart Hospital, Spokane

St. Elizabeth's Hospital, North Yakima

St. Joseph's Hospital, Tacoma

St. Luke's Hospital, Spokane

St. Mary's Hospital, Walla Walla

Seattle City Hospital, Seattle

Seattle General Hospital, Seattle

Swedish Hospital, Seattle

Tacoma General Hospital, Tacoma

50 to 100 beds

\*Minor Hospital, Seattle

\*St. Joseph's Hospital, Aberdeen

Virginia Mason Hospital, Seattle

## WEST VIRGINIA

100 or more beds

Charleston General Hospital, Charleston

Kessler-Hatfield Hospital, Huntington

Ohio Valley Hospital, Wheeling

St. Mary's Hospital, Clarksburg

Sheltering Arms Hospital, Hansford

\*Welch Hospital No. 1, Welch

Wheeling Hospital, Wheeling

50 to 100 beds

\*Beckley Hospital, Beckley

\*Bluefield Sanitarium, Bluefield

\*Chesapeake and Ohio Hospital, Huntington

Coal Valley Hospital, Montgomery

Davis Memorial Hospital, Elkins

\*Guthrie Hospital, Huntington

\*McKendree Hospital No. 2, McKendree

\*St. Luke's Hospital, Bluefield

## WISCONSIN

100 or more beds

LaCrosse Lutheran Hospital, LaCrosse

Luther Hospital, Eau Claire

Madison General Hospital, Madison

Mercy Hospital, Janesville

Milwaukee County Hospital, Milwaukee

Milwaukee Hospital, Milwaukee

Mt. Sinai Hospital, Milwaukee

St. Agnes Hospital, Fond du Lac

St. Francis Hospital, LaCrosse

St. Joseph's Hospital, Marshfield

St. Joseph's Hospital, Milwaukee

St. Mary's and Mercy Hospitals, Oshkosh

St. Mary's Hospital, Green Bay

\*St. Mary's Hospital, Milwaukee

\*St. Mary's Hospital, Superior

Trinity Hospital, Milwaukee

50 to 100 beds

Columbia Hospital, Milwaukee

\*Evangelical Deaconess Hospital, Milwaukee

Grandview Hospital, LaCrosse

\*Holy Family Hospital, Manitowoc

\*LaCrosse Public Hospital, LaCrosse

Milwaukee Children's Hospital, Milwaukee

\*Milwaukee Maternity and General Hospital, Milwaukee

\*Misericordia Hospital, Milwaukee

St. Elizabeth's Hospital, Appleton

St. Joseph's Hospital, Dodgeville

St. Mary's Hospital, Madison

St. Mary's Hospital, Racine

## WYOMING

50 to 100 beds

\*Wheatland Hospital, Wheatland

## CANADA

## ALBERTA

100 or more beds

General Hospital, Calgary

General Hospital, Edmonton

Holy Cross Hospital, Calgary

Medicine Hat Hospital, Medicine Hat

Misericordia Hospital, Edmonton

Royal Alexandra Hospital, Edmonton

50 to 100 beds

\*Galt Hospital, Lethbridge

Lamont Public Hospital, Lamont

## BRITISH COLUMBIA

100 or more beds

Provincial Royal Jubilee Hospital, Victoria

Royal Columbian Hospital, New Westminster

Royal Inland Hospital, Kamloops

St. Joseph's Hospital, Victoria

St. Paul's Hospital, Vancouver

Vancouver General Hospital, Vancouver

50 to 100 beds

\*Vernon Jubilee Hospital, Vernon

## MANITOBA

100 or more beds

Brandon General Hospital, Brandon

Children's Hospital, Winnipeg

Misericordia Hospital, Winnipeg

St. Boniface Hospital, St. Boniface

Winnipeg General Hospital, Winnipeg

50 to 100 beds

\*Victoria Hospital, Winnipeg

## NEW BRUNSWICK

100 or more beds

General Public Hospital, St. John

50 to 100 beds

\*Chipman Memorial Hospital, St. Stephen

Hotel Dieu, Campbellton

Hotel Dieu, Chatham

Miramichi Hospital, Newcastle

Moncton Hospital, Moncton

St. John's Infirmary, St. John

Victoria Public Hospital, Fredericton

## NOVA SCOTIA

100 or more beds

St. Joseph's Hospital, Glace Bay

Salvation Army Maternity Hospital, Halifax

Victoria General Hospital, Halifax

50 to 100 beds

Aberdeen Hospital, New Glasgow

Children's Hospital, Halifax

\*General Hospital, Glace Bay

Highland View Hospital, Amherst

\*St. Martha's Hospital, Antigonish

## ONTARIO

100 or more beds

Carleton County Protestant General Hospital, Ottawa

General Hospital, Kingston

General Hospital, Toronto

Grace Hospital, Toronto

Hamilton City Hospital, Hamilton

Hotel Dieu, Kingston

McKellar General Hospital, Ft. William

Ottawa General Hospital, Ottawa

St. Joseph's Hospital, Hamilton

\*St. Joseph's Hospital, London

St. Joseph's Hospital, Port Arthur

St. Luke's Hospital, Ottawa

St. Michael's Hospital, Toronto

Sick Children's Hospital, Toronto

Victoria Hospital, London

\*Western Hospital, Toronto

50 to 100 beds

\*General Hospital, Brockville

\*General Hospital, Sault Ste. Marie

Niagara Falls General Hospital, Niagara Falls

\*Nicholls Hospital, Peterborough

\*St. Francis Hospital, Smith's Falls

\*St. Joseph's Hospital, Peterborough

\*St. Vincent de Paul Hospital, Brockville

\*Smith's Falls Public Hospital, Smith's Falls

\*Welland County Hospital, Welland

Wellesley Hospital, Toronto

Women's College Hospital, Toronto

## PRINCE EDWARD ISLAND

50 to 100 beds

Charlottetown Hospital, Charlottetown

Prince Edward Island Hospital, Charlottetown

## QUEBEC

100 or more beds

Children's Memorial Hospital, Montreal

General de St. Vincent Hospital, Sherbrooke

Hotel Dieu, Montreal

Jeffery Hale's Hospital, Quebec

Montreal General Hospital, Montreal

Notre Dame Hospital, Montreal

Royal Victoria Hospital, Montreal

Sainte Justine Pour Les Enfants, Montreal

\*Western Hospital, Montreal

50 to 100 beds

Montreal Maternity Hospital, Montreal

\*Sherbrooke Hospital, Sherbrooke

## SASKATCHEWAN

100 or more beds

Grey Nuns Hospital, Regina

Regina General Hospital, Regina

St. Paul's Hospital, Saskatoon

Saskatoon City Hospital, Saskatoon

50 to 100 beds

Holy Family Hospital, Prince Albert

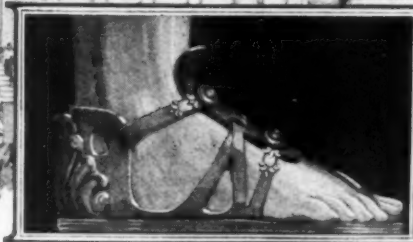
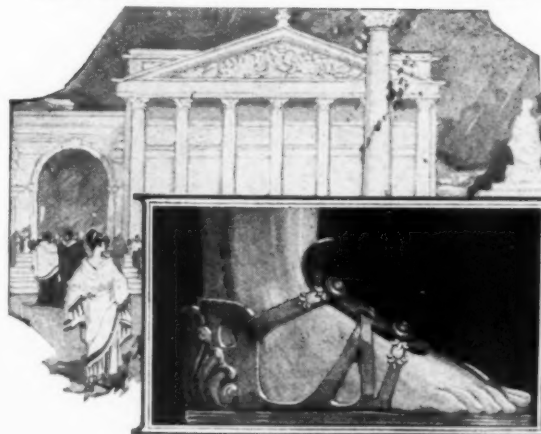
\*Notre Dame Hospital, North Battleford

\*Prince Albert Municipal Hospital (Victoria Hospital), Prince Albert

Providence Hospital, Moose Jaw



## A New Idea in Shoes that is 2000 years old



IN the days of old Rome the people wore sandals, designed primarily to support the foot as Nature requires. The sandal afforded a foot-length support, just like going "bare-footed." There is no record of foot weakness or discomfort in those early days.

But Civilization, in its eagerness to secure more stylish apparel, adopted the heel. This marked the end of the natural foot-length support. The foot arch was allowed to sag, subject to a constant strain. Today ninety percent of all women suffer with their feet largely because the arch is not properly supported as Nature planned.

The Arch Preserver Shoe—a new idea in shoes that is 2,000 years old—has revived the sandal comfort and healthfulness. Its concealed, built-in arch bridge gives the foot the same support as when walking "barefooted"—keeps the arch from sagging while the heel is raised from the ground—in the smartest shoes that Fashion knows.

The Arch Preserver Shoe is the *only* shoe of its kind because its distinctive construction is *patented*. To satisfy both Nature and Fashion you therefore must be sure that you are buying the genuine Arch Preserver. This trade-mark on the sole and lining is your guarantee.



"KEEPS THE FOOT WELL"

Arch Preserver Boots and Low-Cuts are made for Women and Misses in all styles—and in all widths, AAAA to E. Sold by 2,000 dealers.

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74 Gallia St., Portsmouth, Ohio  
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Nature plans that the foot rest on heel, ball and outside arch.



Civilization demands that heel and arch be raised.

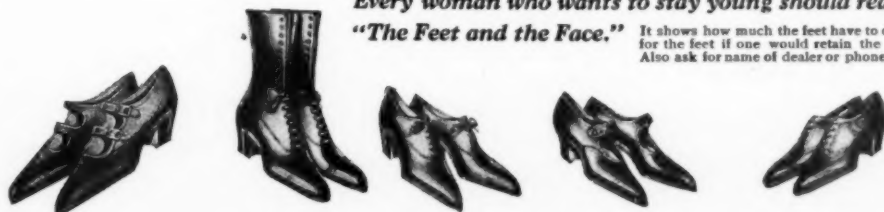


The Arch Preserver Shoe satisfies both Nature and Civilization.

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Every woman who wants to stay young should read this booklet,  
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dealer.  
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Street and No. ....  
P. O. .... State .....

## FOREIGN CORRESPONDENCE

### WOULD HAVE BRITISH HOSPITALS PART OF STATE MEDICAL SERVICE

BY OUR LONDON CORRESPONDENT

THE hospital question is still pending in this country and even an approach to a settlement seems far away. As a matter of fact those responsible for the management of these institutions are on the horns of a dilemma. While they recognize that drastic changes must be made, they are wedded to the voluntary system and are unwilling to take steps which may tend to impair it or imperil it. The medical profession dreads state control which might, and probably would, place its members in the power of the approved societies which are politically influential, while the medical profession is practically impotent in this direction. On the other hand it is plainly evident that strong efforts must be made at once to render the hospitals financially secure and various schemes have been mapped out, some of which have been put into practice to attain this end.

A conference between the Voluntary Hospitals Commission and representatives of the local voluntary hospital committees was held recently at the Ministry of Health. At this conference several important phases of the hospital situation were discussed by experts and plans suggested to relieve the tension. The chairman, Lord Onslow, explained that the object of the government, of the commission and of the local committees was to maintain intact the voluntary system and the minister of health has asked him to lay stress on this fundamental consideration. Their first duty was to administer the grant of \$2,500,000 voted by the government. For this purpose the local voluntary hospital committees had been established.

In London the duties of a local committee had been undertaken by King Edward's Hospital Fund. In no case had the grant exceeded more than one-half of the estimated deficit on maintenance account for the year 1921. The estimate of Lord Cave's committee of the deficit of the London hospitals was \$2,315,000. King Edward's Fund had reported, however, that the actual deficit was \$1,600,000. In London a combined appeal had been launched with marked success. In the rest of the country fifty-four voluntary hospital committees were operating, and there were only eight areas in which committees had not yet been established. As regards the bulk allocation of the total sum at the commission's disposal, as between London and the provinces, it had resolved, subject to a final adjustment of the figures, that \$1,125,000, including the amounts already voted, be ap-

propriated to London, and \$1,375,000, including the sums already voted, to the remaining areas. The information before the commission went to show that the cost of maintenance was declining, while income was being maintained and in many cases rising. In the discussion which followed Mr. H. N. Crouch spoke of the difficulties in securing coordination and economies because the hospitals were apt to regard themselves as isolated units. The lack of system tended to waste in accommodation and in the medical services. He proposed the following resolution: "That the voluntary hospitals' areas be so re-grouped that each area constitute a suitable unit in which to make the attempt to effect coordination between existing hospitals and gradually to create a complete and properly conducted hospital system on a voluntary basis.

With regard to the difficulties which local committees experience in obtaining information on the methods pursued in other areas Mr. Davis, Manchester, suggested that the commission should issue a pamphlet on the methods which have secured the high standard of excellence in some of the best hospitals, giving particulars of the control and administration of the hospital, how it reaches the public, and how the public regard it. Speaking of the need for systematic collection from employees and workers, he stated that the public was anxious to maintain voluntary hospitals; the difficulty was to create facilities through which help could be given. In particular the crux lay in getting to the employee through the employer, who did not always facilitate entree to his works. He suggested that the commission should approach the Federation of British Industries, and urged that steps should be taken to obtain the sympathy of labor leaders and to secure an expression of opinion from them that they are not averse from the payment of weekly contributions by working people.

At about the same time at which this conference was held the question of hospitals and state medical service was discussed at a conference of the Social Democratic Federation held in London. Dr. Illis Morgan gave an address on the matter in which he advocated that hospitals should be part of the state medical service and he asked what the voluntary philanthropic efforts have attained. For six months they had had a raging, tearing propaganda in aid of a combined appeal for the hospitals; all sorts of means had been devised to wheedle, cajole, coax and swindle money out of people's pockets and with

*The PREMIER Product of*  
*Posterior Pituitary active principle*



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 for  
 the  
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 A reliable oxytocic, indicated in surgical shock and post  
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 restore peristalsis.

## Suprarenalin Solution

1:1000—Astringent and Hemostatic

Water-white, stable. In 1-oz. bottles, with cup stopper.  
 Of much service in minor surgery. E.E.N. and T. work.

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**FREE OF TAX**

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what result? They clamored for \$2,500,000; they had obtained \$1,500,000 of which \$150,000 had been swallowed up in expenses. The state had done nothing to deal with the underlying causes of disease. The hospitals were the only link in the chain of medical service which was not provided by the state, and which therefore could not be joined up with the others. Those who required special treatment, for which they could not afford to pay, had to go as suppliants and not as having a rightful claim to hospital treatment.

Questioned as to whether the cost of making the hospitals part of the public service would not be prohibitive and whether coordination with the other services would not be almost impossible, Dr. Morgan said his view was that a properly arranged medical service, eliminating the present overlapping, could be obtained at little or no increased cost to the ratepayers. He would reserve the hospitals for casualty cases; and cases requiring special skill and attention should be sent to consultants by the outside general medical service. He would do away with the general out-patient departments. He would also do away with the whole poor law service, and would link up the infirmaries with the hospital service.

The cases which now filled up the out-patient departments of the hospitals and these treated in the poor law infirmaries he would deal with by an extension modification of the national insurance system. Under the latter the working man for the first time would choose his own doctor; under the old club system the local committee selected his doctor. Another great merit of the scheme was that the doctor working in the poorer districts to alleviate the sufferings of those around him was at last assured of a decent remuneration for his labors. If they linked up a modified rational insurance scheme with the special treatment to be obtained at the hospitals, convalescent homes, sanatoriums and the like, the result to national health would be more satisfactory than it was at the present time.

Without discussion the conference passed a resolution, viewing with regret the present unfortunate position of the hospitals, declaring that it demonstrated the failure of voluntary subscriptions to provide the necessary hospital accommodation, and calling upon the labor party to press "for the immediate socialization of this valuable institution into the service of the nation."

It will be observed that views are very conflicting with respect to the best means to be employed both to place the hospitals on a sound financial basis and at the same time to give the most efficient service to the public.

### BOOKS RECEIVED

**PHYSICAL DIAGNOSIS.** By W. D. Rose, M.D., Lecturer on Physical Diagnosis and Associate Professor of Medicine in the University of Arkansas; Visiting Physician, Little Rock City Hospital, Baptist Hospital, and St. Vincent's Infirmary, Little Rock, Ark. Third edition, with 319 illustrations. C. V. Mosby Company, St. Louis, 1922.

**DISEASES OF THE THYROID GLAND.** By Arthur E. Hertzler, M.D., F.A.C.S., Professor of Surgery in the University of Kansas School of Medicine; Surgeon to Halstead Hospital, Halstead, Kan.; Surgeon to St. Luke's Hospital and St. Mary's Hospital, Kansas City, Mo.; and to Provident Hospital, Kansas City, Kan. With a chapter on *Hospital Management of Goiter Patients* by Victor E. Chesky, A.B., M.D., Associate Surgeon to Halstead Hospital. With 106 original illustrations. C. V. Mosby Company, St. Louis, 1922.

## Book Reviews and Current Hospital Literature

### A HISTORY OF THE NATIONAL TUBERCULOSIS ASSOCIATION

Or The Anti-Tuberculosis Movement in the United States. By S. Adolphus Knopf, M.D., National Tuberculosis Association, 370 Seventh Avenue, New York, 1922.

Seventeen years of organized warfare against tuberculosis are recounted in Dr. S. Adolphus Knopf's volume, "A History of the National Tuberculosis Association." In it are narrated the association's slender beginnings, its early problems and the development of its extensive educational campaign and local organization program. An entire chapter is devoted to the Christmas seal sale and another to the Framingham Community Health and Tuberculosis Demonstration at Framingham, Mass. State associations each get ample space to relate their achievements, and notes on the seventeen annual meetings of the national body are included.

Of genuine interest in the book are the biographies of some fifty officers of the association since its founding. These include biographical sketches of its honorary vice presidents from Grover Cleveland to Warren G. Harding, in addition to regular officers, among whom have been most of the great leaders in tuberculosis work in this country. The biographies are for the most part inspiringly written. Halftones of the various officers accompany the biographical notes.

In appendices to the volume attention is paid anti-tuberculosis work done during and after the World War in the offices of the surgeon generals of army, navy and public health service, the publications of the national association, and comprehensive bibliography of the author, Dr. Knopf.

### OBSTETRICS FOR NURSES

By Joseph B. De Lee, A.M., M.D., Professor of Obstetrics at the Northwestern University Medical School; Obstetrician to the Chicago Lying-In Hospital and Dispensary. Sixth Edition, entirely reset.

This book which is well and favorably known has been thoroughly reviewed and brought up-to-date. Several more pages are devoted to the operation of Cesarean Section, and the methods of the Chicago Lying-In Hospital have been more fully presented. The place of honor is still held by the old and tried methods which enable nurses to meet the emergencies in private homes, which is an inevitable part of obstetrical work.

New illustrations and several new pictures are valuable additions.

<sup>1</sup>W. B. Saunders Company, Philadelphia and London, 1922.

### PHYSIOLOGY AND BIOCHEMISTRY IN MODERN MEDICINE.

By J. J. R. MacLeod, M.D., Professor of Physiology in the University of Toronto, Toronto, Canada. Assisted by Roy G. Pearce, A. C. Redfield and N. B. Taylor and by others. Fourth edition. With 243 illustrations. C. V. Mosby Company, St. Louis, 1922.